National Health Insurance in Taiwan
2011 Annual Report
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Health Insurance for All

Over the past 16 years, the government has successfully provided universal and quality healthcare to the people of Taiwan at affordable cost. In recent years, the Bureau of National Health Insurance (BNHI) has been focusing on ensuring care for socially and economically disadvantaged people, and steadily improving its administrative efficiency and service quality. Today, Taiwan’s National Health Insurance (NHI) system has become a role model of a single-payer social insurance and has earned praise in the international society.

Providing Care for the Socially and Economically Disadvantaged

The BNHI was founded on the idea of marshaling the resources of the majority to relieve the difficulties less fortunate people have in paying for health care. Those who cannot afford their premiums are eligible for assistances from the Bureau. To assist those people in overcoming financial hardship and safeguard their access to care, the BNHI offers a variety of programs, including premium subsidies, relief fund loans, sponsorship referrals, and installment plans.

The Bureau has also promoted an integrated delivery system (IDS) to improve services in the remote mountainous areas and outlying islands. The program brings socially disadvantaged residents in those areas with much needed medical services.
Commitment to Upgrading Care Quality

With the introduction of a global budgeting system, which sets annual spending caps on broad health care sectors, the BNHI must ensure that health care quality in Taiwan will not be compromised due to resource constraints. The Bureau has consistently worked together with the medical institutions to provide quality care that often time goes beyond the call of duty to better satisfy the needs of the insured.

This commitment goes in tandem with the Bureau’s evolutionary process. When the system was first launched in 1995, our main goals were to improve patients' access to health care by easing their financial burdens and to make sure that no one would be forced into bankruptcy by medical bills. With time, the Bureau gradually adjusted our focus to emphasize the quality of health care, as defined by three new objectives. The first is to expand patients’ knowledge by making information on health care quality and services accessible and transparent. The second is to pay greater attention to the quality of medical services delivered to the disadvantaged groups in remote areas and provide equitable and appropriate care. The third is to put greater emphasis on patient safety and making healthcare more patient-oriented.

These three goals have led to the adoption of several measures to upgrade quality and efficiency that have improved the health of Taiwan's people, as testified by a host of indicators. The number of patients receiving holistic treatment for chronic ailments such as asthma and diabetes has risen, as has the overall level of satisfaction with the health care system. Emergency care visits and readmission rates have gradually fallen and the rate of growth of the incidence of major diseases has slowed down.

Capturing International Attention

The NHI system’s success in providing universal coverage and convenient access to care at low premiums while containing the growth of medical expenditures has captured the eyes of many foreign visitors.

In 2009, about 550 visitors from all over the world visited the Bureau and learned about the achievements of the NHI program. And a number of officials from the Bureau were invited to other countries to share our experiences and expertise in managing the system.

This widespread interest from the international community reflects the growing prominence of Taiwan's health insurance system as a health care model for countries around the globe.

Commitment to Improvement

While taking pride in its many achievements, the Bureau is constantly in pursue of further improvement by harnessing such fundamental principles as promoting social equity, increasing efficiency, elevating the quality of care and forging a national consensus. The Bureau has drafted strategic goals and concrete measures that are expected to enhance healthcare functions at every level of the system and strengthen community care. The NHI system benefits all of the country's people and is truly a pride for Taiwan.
Taiwan's social insurance system began with the inception of the Labor Insurance program in 1950, followed by the Government Employee Insurance program in 1958. The scope of enrollment and payments was expanded over time. The Farmers' Health Insurance program was implemented on a pilot basis in 1985 and fully implemented in 1989. To ensure that low income families meet their needs, the Health Insurance for Low Income Households program took effect in 1990.

By the end of 1994, a total of 10 health insurance programs were in place in Taiwan within the social insurance framework. Approximately 59% of the nationals enjoyed medical insurance coverage under these plans or the military medical care system. However, another 8.6 million people (41%) – mostly children, the unemployed, and the elderly – lacked health insurance coverage. The desire to protect the health of the entire population and provide health insurance for every citizen on equal terms shored up the government's resolve to implement the NHI program regardless of the obstacles in the way.
Labor Insurance

Launched on May 1, 1950, the program aimed at the workers of government-run enterprises, private company employees, other blue-collar employees, fishermen, skilled hands, drivers, and janitors of government agencies who were over 15 and under 60 years old. The benefits include cash compensation for childbirth, illness, work-related injuries, and outpatient and inpatient medical services.

Government Employees' Insurance

Started in January 1958, the program covered the employees of government agencies and elected public officers. The benefits included childbirth, physical examination, disease prevention, and medical treatment for injury and illness, etc.

Farmers' Insurance

Beginning on October 25, 1985, the program targeted members of farmer associations and individual farmers who were over 15 years old. The benefits included compensations for childbirth, injury, illness, disability, and death, etc.

National Health Insurance

Prompted by the ideals of implementing universal health coverage, elimination of financial barriers to medical services, and solving social problems caused by poverty and illness, the government sought to integrate the various insurance programs into a more inclusive health care system. The Council for Economic Planning and Development (CEPD) was instructed to start the first-stage planning in 1988. In 1990, the Department of Health (DOH) took over the task and established in 1993 a Preparatory Office for NHI to engage in various preparations.

On August 9, 1994, the NHI past the third reading in the Legislative Yuan and became law. On January 1, 1995, the Bureau of National Health Insurance was established, and on March 1, 1995, the NHI program was launched.
The NHI Administrative Framework

Basic Framework of the NHI System
Taiwan’s NHI system is a social insurance program administered by the government. The three main components of the NHI system are the insured, the contracted healthcare providers and the BNHI (Figure 1). The BNHI collects premiums from the insured and issues them the insurance cards. When the insured use the medical services, they do not need to pay the medical expenses other than a copayment as user fees. The medical providers make claims to BNHI for reimbursement of the services they have provided.

Figure 1  Basic Framework of the NHI System
Organizational Team

The BNHI is the executive organization of the NHI program. The Department of Health has jurisdiction over the Bureau and has established three committees — the NHI Supervisory Committee, the NHI Dispute Mediation Committee, and the NHI Medical Expenditure Negotiation Committee (Figure 2) — to help plan and monitor tasks performed related to the NHI.

The BNHI has the functions of planning, promotion, execution, supervision, research and development, training, information management and auditing. Its operations are funded out of the central government's tax dollars.

In addition to the headquarters, the BNHI has established six regional divisions across Taiwan (Figure 3) that directly handle local insurance applications, premium collection, claims review and reimbursement, and management of contracted medical institutions. Twenty-one liaison offices have been set up around the country to serve the public. As of the end of December 31, 2010, the Bureau had 3,075 employees, all dedicated to providing the highest level of health care to Taiwan's people.

Figure 2  Organization Chart of the Bureau of National Health Insurance
Figure 3
Service Areas of NHI

**Northern Division:**
Location: Chungli City
Jurisdictional District:
Taoyuan County, Hsinchu City, Hsinchu County, Miaoli County

**Central Division:**
Location: Taichung City
Jurisdictional District:
Taichung City, Changhua County, Nantou County

**Southern Division:**
Location: Tainan City
Jurisdictional District:
Yunlin County, Chiayi County, Chiayi City, Tainan City

**Kaoping Division:**
Location: Kaohsiung City
Jurisdictional District:
Kaohsiung City, Pingtung County, Penghu County
Taipei Division:
Location: Taipei City
Jurisdictional District: Taipei City
New Taipei City, Keelung City, Yilan County
Kinmen County, Lienchiang County

Eastern Division:
Location: Hualien City
Jurisdictional District: Hualien County and Taitung County
The NHI program is a mandatory, single-payer social health insurance system, founded on the principle that everybody should have equal access to health care services.

**Enrollment Eligibility**

All citizens, except the convicts (who are covered under a separate medical care program), are obligated to participate in the compulsory program. Infants born locally are covered under the program as soon as their births are registered at a local household registration office, but those born abroad shall be covered after meeting the four-month residency requirement.

Foreign nationals who meet the NHI regulations and residency requirements must also be insured under the system. Those hired by local employers are covered from the day their employment contract takes effect, while others must enroll in the system after meeting the four-month residency requirement.

**Eligibility for Overseas Citizens**

R.O.C. citizens who plan to stay abroad for more than six months can either maintain their health insurance or have their insurance status temporarily suspended.
Individuals who reside abroad for more than two years automatically have their household registrations removed and therefore can no longer participate in the NHI program. They can rejoin the system if they re-establish residency in Taiwan at a later date.

Financing

Designed to be financially self-sustained and responsible for its own deficits, the NHI system primarily relies on "pay-as-you-go" financing to balance its accounts in the short-term. By law, the BNHI cannot be for-profit and is required to maintain a reserve fund equal to one month of medical expenditures at least.

The system is primarily funded by the premiums paid collectively by the insured, employers, and the central and local governments. Other revenues come from outside sources, such as fines on overdue premiums, public welfare lottery contributions, and the health surcharge on cigarettes, all of which supplement the system's income after meeting the mandated reserve fund's basic funding needs.

The NHI Act, the statutory foundation of the health insurance system passed in 1994, stipulates that premium rates must be reviewed and re-calculated every two years to ensure the system's financial sustainability. During these periodic reviews, the Bureau estimates revenues and expenditures for 25 years into the future and then determines the premium rate that will balance the two. The results are given to policy planners as a reference for future adjustments in premiums and long-term health policy. It must be noted, however, that in the system's 16 years of existence, the premium rate has only been adjusted twice.

The NHI premium rate was 4.25% from the time the system came into being until September 2002, when it was adjusted to 4.55%. The premium rate was then adjusted to 5.17% in April 2010.
Classification of the Insured

The insured are divided into six categories based mainly on occupation status, and how their premiums are calculated and paid are determined according to the category (Table 1).

The relative contributions shared by the insured, their employers or insurance registration organizations and the government vary by category. For those employed in the private sector, the employee pays 30% of the premium, the employer 60% and the government 10%. The government foots the bill for individuals grouped in categories 4 and 5.

Table 1  NHI Premium Contribution Ratios

<table>
<thead>
<tr>
<th>Classification of the Insured</th>
<th>Contribution Ratios (%)</th>
<th>Insured</th>
<th>Employers</th>
<th>Gov’t</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil servants, volunteer servicemen, public office holders</td>
<td>Insured and dependents</td>
<td>30</td>
<td>70</td>
<td>0</td>
</tr>
<tr>
<td>Private school teachers</td>
<td>Insured and dependents</td>
<td>30</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Employees of publicly or privately owned enterprises or institutions</td>
<td>Insured and dependents</td>
<td>30</td>
<td>60</td>
<td>10</td>
</tr>
<tr>
<td>Employers Self-employed Independent professionals and technical specialists</td>
<td>Insured and dependents</td>
<td>100</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Category 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation union members Foreign crew members</td>
<td>Insured and dependents</td>
<td>60</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td><strong>Category 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members of farmers’, fishermen’s and irrigation associations</td>
<td>Insured and dependents</td>
<td>30</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td><strong>Category 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Military conscripts, alternative servicemen, military school students on scholarships</td>
<td>Insured</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td><strong>Category 5</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low-income household</td>
<td>Household members</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td><strong>Category 6</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans and their dependents</td>
<td>Insured</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Dependents</td>
<td></td>
<td>30</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td>Other individuals</td>
<td>Insured and dependents</td>
<td>60</td>
<td>0</td>
<td>40</td>
</tr>
</tbody>
</table>
Premium Calculation

Premiums are calculated as a percentage of an individual's payroll, capped at NT$182,000 per month, and shared by the individual, the individual's employer and the government. Those classified in categories 1, 2, and 3 listed above pay premiums based on their payroll, while the premiums for those classified in categories 4, 5 and 6 are based on the average premium paid by all individuals participating in the system. (For a detailed explanation, please see Table 2.)

The average number of dependents per insured has been steadily declining, going from 1.36 dependents in December 1995, to 0.7 on January 1, 2007. When the system came into effect in 1995, the employers' contributions was assessed based on an average number of dependents per employee so as to avoid employer’s discrimination against individuals with a high number of dependents.

Table 2  NHI Premium Formulas

<table>
<thead>
<tr>
<th>Insured Category</th>
<th>Contributor</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wage Earners</td>
<td>The Insured</td>
<td>Payroll Basis x Premium Rate x Contribution Ratio x (1 + Number of Dependents)</td>
</tr>
<tr>
<td></td>
<td>Insurance Registration Unit or the Government</td>
<td>Payroll Basis x Premium Rate x Contribution Ratio x (1 + Average Number of Dependents)</td>
</tr>
<tr>
<td>Non-wage Earning Individuals</td>
<td>The Insured</td>
<td>Average Premium x Contribution Ratio x (1 + Number of Dependents)</td>
</tr>
<tr>
<td></td>
<td>The Government</td>
<td>Average Premium x Contribution Ratio x (1 + Actual Number of Dependents)</td>
</tr>
</tbody>
</table>

NOTES:
1. Payroll Basis: Amount of payroll on which premiums are levied based on a bracket table (Table 3).
2. Insurance Premium Rate: 5.17% since April 1, 2010.
3. Contribution Ratios: Based on ratios set by the BNHI (Table 1).
4. Number of Dependents: Maximum of three even if the actual number of dependents is higher.
5. Average Number of Dependents: Set by the BNHI at 0.7 as of Jan. 1, 2007.
6. Since October 2009, the average monthly premium for individuals in categories 4 and 5 has been NT$1,376, which is entirely subsidized by the government. For individuals in category 6, the average premium is NT$1,249, with 60% paid for by the individual (NT$749) and 40% by the government effective from April 1, 2010.
Table 3  Payroll Brackets on which Premiums Are Charged

<table>
<thead>
<tr>
<th>Brackets</th>
<th>Tiers</th>
<th>Chargeable Payroll (NT$)</th>
<th>Actual Monthly Payroll (NT$)</th>
<th>Brackets</th>
<th>Tiers</th>
<th>Chargeable Payroll (NT$)</th>
<th>Actual Monthly Payroll (NT$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bracket 1</td>
<td>1</td>
<td>17,880</td>
<td>Under 17,880</td>
<td>Bracket 6</td>
<td>28</td>
<td>60,800</td>
<td>57,801-60,800</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>18,300</td>
<td>17,881-18,300</td>
<td></td>
<td>29</td>
<td>63,800</td>
<td>60,801-63,800</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>19,200</td>
<td>18,301-19,200</td>
<td></td>
<td>30</td>
<td>66,800</td>
<td>63,801-66,800</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>20,100</td>
<td>19,201-20,100</td>
<td></td>
<td>31</td>
<td>69,800</td>
<td>66,801-69,800</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>21,000</td>
<td>20,101-21,000</td>
<td></td>
<td>32</td>
<td>72,800</td>
<td>69,801-72,800</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>21,900</td>
<td>21,001-21,900</td>
<td></td>
<td>33</td>
<td>76,500</td>
<td>72,801-76,500</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>22,800</td>
<td>21,901-22,800</td>
<td></td>
<td>34</td>
<td>80,200</td>
<td>76,501-80,200</td>
</tr>
<tr>
<td>Bracket 2</td>
<td>8</td>
<td>24,000</td>
<td>22,801-24,000</td>
<td></td>
<td>35</td>
<td>83,900</td>
<td>80,201-83,900</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>25,200</td>
<td>24,001-25,200</td>
<td></td>
<td>36</td>
<td>87,600</td>
<td>83,901-87,600</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>26,400</td>
<td>25,201-26,400</td>
<td></td>
<td>37</td>
<td>92,100</td>
<td>87,601-92,100</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>27,600</td>
<td>26,401-27,600</td>
<td></td>
<td>38</td>
<td>96,600</td>
<td>92,101-96,600</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>28,800</td>
<td>27,601-28,800</td>
<td></td>
<td>39</td>
<td>101,100</td>
<td>96,601-101,100</td>
</tr>
<tr>
<td>Bracket 3</td>
<td>13</td>
<td>30,300</td>
<td>28,801-30,300</td>
<td></td>
<td>40</td>
<td>105,600</td>
<td>101,101-105,600</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>31,800</td>
<td>30,301-31,800</td>
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<td>41</td>
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<td>105,601-110,100</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>33,300</td>
<td>31,801-33,300</td>
<td></td>
<td>42</td>
<td>115,500</td>
<td>110,101-115,500</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>34,800</td>
<td>33,301-34,800</td>
<td></td>
<td>43</td>
<td>120,900</td>
<td>115,501-120,900</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>36,300</td>
<td>34,801-36,300</td>
<td></td>
<td>44</td>
<td>126,300</td>
<td>120,901-126,300</td>
</tr>
<tr>
<td>Bracket 4</td>
<td>18</td>
<td>38,200</td>
<td>36,301-38,200</td>
<td></td>
<td>45</td>
<td>131,700</td>
<td>126,301-131,700</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>40,100</td>
<td>38,201-40,100</td>
<td></td>
<td>46</td>
<td>137,100</td>
<td>131,701-137,100</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>42,000</td>
<td>40,101-42,000</td>
<td></td>
<td>47</td>
<td>142,500</td>
<td>137,101-142,500</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>43,900</td>
<td>42,001-43,900</td>
<td></td>
<td>48</td>
<td>147,900</td>
<td>142,501-147,900</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>45,800</td>
<td>43,901-45,800</td>
<td></td>
<td>49</td>
<td>150,000</td>
<td>147,901-150,000</td>
</tr>
<tr>
<td>Bracket 5</td>
<td>23</td>
<td>48,200</td>
<td>45,801-48,200</td>
<td></td>
<td>50</td>
<td>156,400</td>
<td>150,001-156,400</td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>50,600</td>
<td>48,201-50,600</td>
<td></td>
<td>51</td>
<td>162,800</td>
<td>156,401-162,800</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>53,000</td>
<td>50,601-53,000</td>
<td></td>
<td>52</td>
<td>169,200</td>
<td>162,801-169,200</td>
</tr>
<tr>
<td></td>
<td>26</td>
<td>55,400</td>
<td>53,001-55,400</td>
<td></td>
<td>53</td>
<td>175,600</td>
<td>169,201-175,600</td>
</tr>
<tr>
<td></td>
<td>27</td>
<td>57,800</td>
<td>55,401-57,800</td>
<td></td>
<td>54</td>
<td>182,000</td>
<td>Above 175,601</td>
</tr>
</tbody>
</table>

*Table took effect from January 1, 2011.*
To determine the income level on which premiums for individuals classified in categories 1, 2 and 3 above are based, the Department of Health establishes a periodically updated payroll bracket table that is then approved by the Executive Yuan. The most recent table, which took effect on January 1, 2011, consists of 54 tiers (Table 3). The income levels of individuals in category 1 on which premiums are levied are based on where their actual incomes fit on the table. Union members in category 2 must report income of at least NT$21,900 per month. The insured in category 3 pay premiums based on the pre-set monthly income level of NT$21,900.

Insurance Benefits

The NHI system offers a comprehensive and uniform benefits package to all those covered by the program. With a valid health insurance card, the insured have access to more than 19,000 contracted health care facilities around the country offering inpatient and ambulatory care, dental services, traditional Chinese medicine therapies, child delivery services, physical rehabilitation, home nursing care, and chronic mental illness care among others.

The system covers most forms of treatment, including surgeries, and related expenses such as examinations, laboratory tests, prescription medications, supplies, nursing care, hospital rooms, and certain OTC drugs. The NHI also covers certain preventive services, such as pediatric and adult health exams, prenatal checkups, pap smears, and preventive dental health checks, with the health promotion budget from Bureau of Health Promotion.
Copayment System

Copayment for Outpatient Services

The copayments for outpatient and emergency care were adjusted several times during the system's first 10 years. But in July 2005, the BNHI revised the copayment fee schedule and referral system to encourage patients to seek treatment for minor ailments at local clinics while leaving regional hospitals free to focus on secondary care and medical centers to focus on tertiary care.

The copayment fee for a visit to a clinic is NT$50. If patients go directly to hospitals for outpatient care without a referral from a clinic or another hospital will pay a higher copayment. The copayment for visits to dentists and traditional Chinese medicine clinics is uniformly NT$50 (Table 4).

<table>
<thead>
<tr>
<th>Institution Class</th>
<th>Type of Institution</th>
<th>Western Medicine Outpatient Care</th>
<th>Emergency Care</th>
<th>Dental Care</th>
<th>Traditional Chinese Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>With Referral</td>
<td>Direct Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Centers</td>
<td></td>
<td>210</td>
<td>360</td>
<td>450</td>
<td>50</td>
</tr>
<tr>
<td>Regional Hospitals</td>
<td></td>
<td>140</td>
<td>240</td>
<td>300</td>
<td>50</td>
</tr>
<tr>
<td>District Hospitals</td>
<td></td>
<td>50</td>
<td>80</td>
<td>150</td>
<td>50</td>
</tr>
<tr>
<td>Clinics</td>
<td></td>
<td>-</td>
<td>50</td>
<td>150</td>
<td>50</td>
</tr>
</tbody>
</table>

Notes:
1. Individuals classified as disabled pay copayments of NT$50 for any medical care, regardless of the type of medical institutions they visit.
2. Patients who return for their first checkup after an outpatient procedure, or within 30 days after being discharged from the hospital, or within 42 days after giving birth, pay the same copayment as if they were given a referral as long as they have a hospital certificate confirming the need for a follow-up visit.
3. This copayment schedule took effect on July 15, 2005.
Copayment for Drugs

If medication prescribed to a patient exceeds a certain cost, a modest copayment for the drugs is also charged (table 5). Follow-up rehabilitation or traditional Chinese medicine treatments for the same course of therapy also carry copayments of NT$50.

<table>
<thead>
<tr>
<th>Drug Expenses (NT$)</th>
<th>Copayment (NT$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 and below</td>
<td>0</td>
</tr>
<tr>
<td>101~200</td>
<td>20</td>
</tr>
<tr>
<td>201~300</td>
<td>40</td>
</tr>
<tr>
<td>301~400</td>
<td>60</td>
</tr>
<tr>
<td>401~500</td>
<td>80</td>
</tr>
<tr>
<td>501~600</td>
<td>100</td>
</tr>
<tr>
<td>601~700</td>
<td>120</td>
</tr>
<tr>
<td>701~800</td>
<td>140</td>
</tr>
<tr>
<td>801~900</td>
<td>160</td>
</tr>
<tr>
<td>901~1000</td>
<td>180</td>
</tr>
<tr>
<td>1001 and above</td>
<td>200</td>
</tr>
</tbody>
</table>

Copayment for Inpatient Care

A progressive copayment rate is applied to hospitalization according to the type of wards (acute or chronic) and length of stay (Table 6). The longer the stay is, the higher the copayment will be. This system is designed to encourage patients to leave the acute wards once their condition has stabilized. But to ease the inpatients' financial burden, caps are placed on copayment as follows: NT$28,000 for a single hospital stay for a particular condition and NT$47,000 cumulative for the entire calendar year.

<table>
<thead>
<tr>
<th>Ward</th>
<th>5%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>-</td>
<td>30 days or less</td>
<td>31-60 days</td>
<td>61 days or more</td>
</tr>
<tr>
<td>Chronic</td>
<td>30 days or less</td>
<td>31-90 days</td>
<td>91-180 days</td>
<td>181 days or more</td>
</tr>
</tbody>
</table>
Copayment Exemptions

The NHI system exempts specific groups from copayments to ensure that the payments do not discourage patients from seeking necessary medical attention. Based on Article 36 of the NHI Act, copayments are not required for those suffering from catastrophic illnesses or living in remote mountain areas or offshore islands, or women giving birth. Others exempted from copayments include veterans and household dependents of deceased veterans, low-income households, children under the age of three, and registered tuberculosis patients who receive treatment at specified contracted hospitals.

Patients being treated for occupational ailments who are covered by labor insurance or those suffering from PCB (polychlorinated biphenyl) poisoning are also not subject to copayments.

Outpatient drug copayments are waived for special cases, holders of refillable prescriptions for chronic conditions, or those receiving dental care.

Contracting Healthcare Providers

The BNHI contracts with qualified healthcare institutions to provide medical services to the insured and reimburses them according to a fee schedule. The healthcare institutions the BNHI contracts include hospitals, clinics, pharmacies, medical laboratories, midwife clinics, home nursing care institutions, psychiatric community rehabilitation centers, physical therapy clinics and others. By the end of 2010, about 92.13% of the healthcare institutions in Taiwan had entered contracts with the BNHI.

Payment System

A sound payment system is necessary to keep NHI program financially balanced and has a great impact on the efficiency and quality of medical care, the distribution of medical resources, and administrative efficiency.

Global Budget Payment System

During the NHI system's early years, Taiwan's health care providers were reimbursed based on a "fee-for-service" basis, which led to a spiraling growth of medical cost. In order to keep health care costs under control without a decline in quality of care, a global budgeting system was phased in between 1998 and 2002, capping overall expenditures in four medical sectors — dental (implemented in July 1998), traditional Chinese medicine (July 2000), Western medicine clinics (July 2001) and hospitals (July 2002). Another sector, ESRD (end-stage renal disease), has since also come under a global budget.

Under the global budget payment system, the NHI Medical Expenditure Negotiation Committee convenes and negotiates overall caps on total medical payments based on a set of equations and indicators prior to the beginning of a fiscal year. A complex negotiating process is held every year to set the annual budget, as described in Figure 4.
Figure 4  Annual Global Budget Determination Process

- Department of Health Drafts Global Budget (Jan. to April)
- Executive Yuan Approves the Budget (May to June)
- NHI Medical Expenditure Negotiation Committee Negotiates Budget Allocation (Aug. to Dec.)
- BNHI Entrusts Medical Groups for Peer Review (Oct. to Dec.)

- Estimating Revenues Based on Anticipated Expenditures
- Review by the Council for Economic Planning and Development
- Estimating Expenditures Based on Anticipated Revenues
- Peer Review

1. Sectors’ Growth Targets
2. Nature of Expenditures Increases and Predicted Effectiveness
3. Review of Related Formulas
1. General Economic Situation
2. Public’s Ability to pay
3. Health Care Expenditures
1. Willingness to pay
2. NHI Financial Considerations
3. Value of Enrolling in NHI
1. Promote the Proficiency of Peer Review
2. Health Care Quality Enhancement
A fee schedule covering more than 4,526 medical service items, 8,769 medical devices and materials, and 16,000 drugs, remains the main base used by the Bureau to reimburse providers with a pre-decided reimbursement cap.

Other Payment Methods

To better manage the medical expenditures and enhance the professional autonomy of medical providers, other payment methods have been introduced, such as Pay-for-Performance, and a Taiwanese version of the Diagnosis Related Groups (Tw-DRGs).

The Bureau started planning for a Taiwanese version of the DRGs since 2000. The classification framework of Tw-DRGs has been developed to reflect the local healthcare needs. The Bureau has but adopted 164 diagnosis-related groups into practice since January 2010, and the DRG payment system would take 5 years to phase in the complete; the total number of diagnosis-related groups is 1029.

The “pay-for-performance” system tries to go beyond simply purchasing medical treatment on behalf of the insured and instead stresses the concept of “buying health.” The pay-for-performance system, first introduced in 2001, is currently being used for breast cancer therapy, diabetes, asthma and hypertension treatment. Schizophrenia and hepatitis B and C carriers were added in 2010, and chronic kidney disease was added in 2011.

Moreover, a RBRVS (resource-based relative value scale) system was adopted in 2004 to further reflect the relative input of medical resources in each medical service. Under the RBRVS system, relative values are assigned to medical services, with the value of a specific service being assessed based on the medical resources used to provide it. Relative values are also adjusted periodically through consultations with experts from different specialties.
Claims Review System

In accordance to the Regulations Governing the Review of the Medical Services, the BNHI is required to review reimbursement claims filed by contracted medical institutions and to screen the type, volume, quality and appropriateness of medical services provided under the NHI program. The sheer volume of claims and the medical expertise needed to review them pose formidable challenges to the reviewing process. To cope with the heavy loading of claims reviewing, the BNHI has developed an automated claims review system with its own internal logic that can weed out those that do not conform to the NHI fee schedule, the drug list, clinical guidelines, and patient conditions (such as age, gender, and indications) etc. It also helps to conduct profile analysis to monitor service utilization abnormalities among hospitals. Those outliers will be picked up to undergo closer peer scrutiny.

The review process includes two parts: procedural reviews and professional reviews. If any of the health care providers submits medical service claims that are found to have violated insurance regulations, they will not be reimbursed, with the reason noted on the file.

Professional reviews of selected claims are conducted by a panel of related medical experts. The BNHI trains and orients panel members on the workings of the insurance system and applicable standards and brings a consensus on review standards among the specialists from different fields on the panel.

According to the NHI Act, if a health care provider disagrees with the result of an audit, it can appeal against the decision. The Bureau then commissions another peer review to evaluate the case for a second time. If the medical institution is still dissatisfied with the result after the second hearing of its case, it can appeal to the Department of Health’s Dispute Mediation Committee, composed of medical experts selected by the Department, which will serves as a device of grievance before the case makes its way to the judicial process.
The NHI program has successfully provided universal coverage, health care of up-to-par quality, comprehensive benefits, and convenient access to treatment, while keeping premiums low and health care expenditures under control.

Socially and economically disadvantaged households have uncompromised access to the system through the many subsidies provided by the Bureau, and average households are protected from the fear of losing their health insurance or going bankrupt over medical bills.

These many advantages have made it one of Taiwan’s most successful public programs, with satisfaction ratings consistently above 70%.

Universal Coverage

The mission of Taiwan’s compulsory NHI system is to provide universal coverage and guarantee equal access to health care services. By the end of 2008, 99.48% of the population was enrolled in the program.

As of December 31, 2010, there are 23,074,487 people enrolled in the NHI program, and among the six insured categories, insured in the first category were most numerous at over 12 million persons, accounting for over half of enrollees (Table 7).

Table 7  Number of People Enrolled in Health Insurance System by Insured Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
<th>Category 5</th>
<th>Category 6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Insured</td>
<td>12,240,752</td>
<td>3,976,004</td>
<td>2,828,337</td>
<td>157,576</td>
<td>271,211</td>
<td>3,600,607</td>
<td>23,074,487</td>
</tr>
<tr>
<td>% of Total Insured</td>
<td>53.05%</td>
<td>17.23%</td>
<td>12.26%</td>
<td>0.68%</td>
<td>1.18%</td>
<td>15.60%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
Access to Health Care

As of 2010, 19,388 hospitals and health care providers, or 92.13% of all health care facilities in the country, were contracted by the NHI system. Another 4,706 pharmacies, 528 home nursing care institutions, 159 psychiatric community rehabilitation centers, 14 midwife clinics, 211 medical laboratories, 15 physical therapy clinics, 9 medical radiology institutions, and 1 occupational therapy clinic were also contracted with the BNHI.

Insured under the NHI program enjoys the freedom to choose any one of these contracted facilities and institutions for treatment. These extensive resources also result in the absence of long waiting times to visit a doctor or undergo surgical procedures or sophisticated tests.

Any individual enrolled in the NHI program can also claim reimbursement for emergency procedures done overseas. Claims must be made within 6 months of the day when the procedures occurred and must include the original copy of the receipt, a detailed list of expenses, a certificate of diagnosis, and proof of exiting and entering the country. The individual should submit the application to a local BNHI office to have the expenses reimbursed.

Financial Status

In 2010, the NHI system totaled revenues of NT$461 billion, with 95% coming from premiums. The remaining 5% came from the health surcharge on cigarettes, contributions from public welfare lotteries, and investment income (Figure 5). Of the premiums, 38% were paid by the insured, 36% by insurance registration organizations (employers), and 26% by government agencies (Figure 6).
On the expenditure side, medical expenditures minus the amount of copayment in 2010 totaled NT$443 billion. Two-thirds (67%) of the total expenditures was for hospital sector, 21% for clinics, 7% for dentals, 4% for Chinese medicine, the remainder (1%) for other designated uses.

A number of factors have propelled the rapid growth of medical expenditures in recent years. These factors include the aging of Taiwan’s society, the inclusion of new drugs and new technologies among items covered under the system, the intensified catastrophic illness care and the general push for improved health care quality. In contrast, revenue growth has remained relatively flat. Premium revenues have not kept pace with growth in real income. As a result of these diverging trends, expenditures have begun outstripping revenues in the early part of the past decade (Figure 7).

Having noticed the need to address the issue of NHI's financial problem, President Ma Ying-jeou proclaimed on March 17, 2010 that to ensure the sustainability of the NHI system, the plan for adjusting the NHI premium rate needs to be implemented as soon as possible. Thereafter, the Department of Health announced that the premium rate would be raised from 4.55% to 5.17% starting from April 1, 2010.

Figure 7  NHI Revenues and Cost Since 1996

- NHI Revenues grew at an average of 4.73% a year (1996-2010)
- NHI Cost grew at an average of 5.03% a year (1996-2010)
However, given the fact that the economy has yet to recover fully from the recession, the government has allocated a budget appropriation to subsidize the difference for citizens with income below a certain specified level, so as to reduce the negative impact of the premium rate increase on the financial burden of the society.

**Administrative Cost**

By law, the ceiling for personnel and administrative cost of BNHI is limited to 3.5% of the total medical expenses, and the budget comes from the Department of Health. Being a single payer in the healthcare market, the BNHI has successfully kept transaction and administrative costs to be around 1.6%.

**Helping the Disadvantaged**

**Subsidy Programs for the Poor**

In a mandatory health insurance program, there will inevitably be an economically marginalized segment of the population that is unable to afford insurance premiums. To ensure that all of Taiwan's citizens have access to care, a social safety net encompassing subsidies and other measures has been created that reinforces the system's spirit of mutual assistance.

A number of preferential aid programs have been designed to help prevent individuals or households from suffering severe financial blows because of a medical condition. The assistance programs available for the poor or seriously ill include premium subsidies, relief loans and installment payment plans. In addition, the NHI system also provides medical and financial assistance to those living in remote areas or those suffering intense financial pressure as they cope with a rare disease.

**“Card-Block Exemption” to underprivileged**

To ensure the underprivileged accessing to the NHI medical services, the Bureau has expanded the coverage to the following type of people: children less than 18 year old; people living in poverty, whose incomes and property are not higher than certain level of the figure deemed as low-income and whose annual household incomes in interest cannot exceed NT$10,000; and people who have experienced domestic violence.

The program of “Card-Block Exemption” has been launched since October 2010. Under the program, a grace period of one year is offered to release the blocked NHI cards held by above-mentioned underprivileged people. By the end of May 2010, about 380,000 people have benefited from the program.
Easing Financial Burdens of Those with Catastrophic Illnesses

The Department of Health defines a list of catastrophic illnesses. The illnesses, from cancer and chronic mental illness to chronic renal failure requiring kidney dialysis and congenital conditions, all cost a lot to treat. Any insured individuals with a certificate proving they have a catastrophic illness are exempt from copayments for treatment of the disease.

As of the end of 2010, more than 820 thousand people, or about 3.5% of all those insured under the NHI program, held valid catastrophic illness certificates. The treatment they received in 2010 cost NT$ 142.7 billion, or 27.13%, of all NHI expenditures, an indication of the commitment the system has made to helping those with major ailments.

Individuals with rare diseases, classified as catastrophic illnesses, are also exempt from paying copayments to safeguard their right to health care. Any drugs listed by the Department of Health as necessary medication for a specific rare disease will also be covered by the NHI system. Patients can even apply on a case-by-case basis to have some drugs not on the NHI’s drug list to be paid for by the program.
IDS Brings Care to Remote Areas

Taiwan has a number of sparsely populated mountainous areas and islands that were unable to attract health care providers and therefore suffered from a lack of uninterrupted health care services. To close this gap, the BNHI initiated an Integrated Delivery System (IDS) in November 1999 that now covers all 48 mountainous and island districts in the country and benefits over 400 thousand people.

Under the program, more than 20 NHI-contracted hospitals rotate medical personnel in and out of the areas to provide medical support services that include outpatient care, 24-hour emergency services, evening and overnight outpatient care, specialty services such as eye, dental and gynecological care. And health care on the mobile vehicle is available. Patients can also get referrals to major hospitals for follow-up care, notably home nursing care, preventive care, disease screening, case management and health education, and remote diagnoses can be made by network hospitals.

In 2010, the IDS program offered an average of 1,884 specialty outpatient sessions per month at a cost of NT$379 million for the year. The additional outpatient services, along with those regularly provided by local hospitals and clinics, drew 4.59 million patient visits at a total cost of NT$3.73 billion. The IDS program had a 93% satisfaction rating as of 2010.
Efficient Payment Schemes

NHI's Total Care Package

The NHI system provides a full range of care, from ambulatory and inpatient care to traditional Chinese medicine, dental services, child delivery, rehabilitation, home nursing care and chronic psychiatric rehabilitation.

As of the end of 2,010, 4,526 services, 8,769 medical devices and 16,511 drugs were covered under the program. Of the drugs, 15,273 were prescription drugs, 1,169 were over-the-counter drugs and 69 were orphan drugs.

The Global Budget Payment System

When the NHI system was being designed, the global budget payment system was the centerpiece of a plan to contain rapid growth in costs under the fee-for-service payment mode and establish a system of financial accountability. It was also legally mandated in the NHI Act.

The global budget payment system has been successful in containing the annual growth in the health insurance system's expenditures with spending growth leveling out at below 5% a year since it was fully imposed in July 2002. The negotiated growth rates for each medical sector's total expenditures between 2003 and 2011 are seen in Table 8.

Table 8  Annual Growth Rates of Global Budgets by Sector

<table>
<thead>
<tr>
<th>Sector</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>3.90%</td>
<td>3.81%</td>
<td>3.61%</td>
<td>4.54%</td>
<td>4.50%</td>
<td>4.47%</td>
<td>3.46%</td>
<td>2.80%</td>
<td>2.69%</td>
</tr>
<tr>
<td>Dental</td>
<td>2.48%</td>
<td>2.64%</td>
<td>2.90%</td>
<td>2.93%</td>
<td>2.61%</td>
<td>2.65%</td>
<td>2.57%</td>
<td>1.94%</td>
<td>1.61%</td>
</tr>
<tr>
<td>Chinese Medicine</td>
<td>2.07%</td>
<td>2.41%</td>
<td>2.51%</td>
<td>2.78%</td>
<td>2.48%</td>
<td>2.51%</td>
<td>2.49%</td>
<td>1.49%</td>
<td>2.37%</td>
</tr>
<tr>
<td>Clinics</td>
<td>2.90%</td>
<td>2.70%</td>
<td>3.23%</td>
<td>4.68%</td>
<td>4.18%</td>
<td>4.13%</td>
<td>3.35%</td>
<td>2.24%</td>
<td>1.72%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>4.01%</td>
<td>4.10%</td>
<td>3.53%</td>
<td>4.90%</td>
<td>4.91%</td>
<td>4.90%</td>
<td>4.46%</td>
<td>2.73%</td>
<td>3.01%</td>
</tr>
</tbody>
</table>

Notes:
1. Figures covering from 2003 to 2011.
2. Figures for 2003-2005 are per capita growth rates in medical expenditures; beginning in 2006, figures are growth rates in overall medical spending.

At the same time that global budgets are being negotiated and approved, other measures are taken to ensure that the global budget payment system will prevent medical sectors or institutions from deteriorating the quality or scope of care because of their capped budgets.
The quality assurance programs agreed to with the medical sectors contain the following provisions:

1. The insured's rights to health care are supervised through satisfaction surveys on health care quality, mechanisms to handle appeals and complaints, and the monitoring of the accessibility of health care.

2. The quality of specialized health care services is ensured, as the Bureau requires hospitals and clinics to:
   
   (1) Establish clinical practice guidelines or pathways and peer reviews, while improving the maintenance of medical records.
   
   (2) Develop ongoing programs to improve health care quality by:
   
   A. Monitoring outpatient environment and service quality
   B. Establishing guidance system for medical institutions
   C. Establishing health care quality indicators and posting quality information on the BNHI website (http://www.nhi.gov.tw) as a reference for medical institutions to help them continue improving the quality of their care.

Pay-for-Performance Plans

The BNHI has developed a series of plans that are structured to improve the quality of care while keeping costs under control. The plans offer health care providers incentives to care for patients' overall well-being and be paid based on clinical outcomes. The Bureau phased in this pay-for-performance system beginning in October 2001 to cover payment for the treatment of cervical cancer, breast cancer, tuberculosis, diabetes, asthma, schizophrenia, hepatitis B and C carriers and chronic kidney disease based on well-defined clinical criteria.

The percentage of patients with the above diseases being treated under clinical outcome-based plans over the past three years is seen in Table 9.

Table 9  Percentage of Patients Treated Under Pay-for-Performance Plan

<table>
<thead>
<tr>
<th>Disease</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>32.50%</td>
<td>34.78%</td>
<td>35.17%</td>
<td>31.29%</td>
<td>31.61%</td>
<td>47.02%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>23.52%</td>
<td>23.16%</td>
<td>24.67%</td>
<td>26.34%</td>
<td>27.56%</td>
<td>29.26%</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>68.78%</td>
<td>78.99%</td>
<td>91.81%</td>
<td>Included in the fee-schedule</td>
<td>Included in the fee-schedule</td>
<td>Included in the fee-schedule</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>12.09%</td>
<td>12.98%</td>
<td>13.60%</td>
<td>14.64%</td>
<td>14.50%</td>
<td>14.62%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>N/A</td>
<td>9.31%</td>
<td>6.54%</td>
<td>3.93%</td>
<td>2.65%</td>
<td>2.55%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40.65%</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9.83%</td>
</tr>
<tr>
<td>and C carriers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The initial results of these plans have been positive. The survival rate of breast cancer patients has improved with the program. The diabetes patients in the program have seen noticeable improvement in key indicators, such as HbA1C. In following up new cases with HBA1C $>$ 9.5% joining the diabetes program, 66% of cases saw improvement in HbA1C after one year in the program. Asthma patients participating in the plan have experienced a gradual decline in their emergency room visits and frequency of hospitalization. Finally, hypertension patients have seen clear improvement in their blood pressure levels.

**Family Doctors**

The BNHI launched a family doctor plan in March 2003 as part of its effort to promote integrated primary care continuity with referrals for more specialized treatment when needed. The program enabled families to obtain primary care through local clinics or neighborhood doctors who are networked with contracted hospitals. These general practitioners serve as preventive medicine consultants who develop complete medical records for every member of the family and provide information on demand. If an ailment requires further tests, surgery or hospitalization, they can arrange for a referral to a larger hospital, saving patients from wasting time and money searching for specialized clinics.

As of June 2011, there were 356 community health care groups in existence, with 2,183 clinics, or 21.46% of the country’s total and 2,478 doctors, or 18.59% of the total, participating in the program.

**Improving Management of Care Delivery**

**Fee Schedule Adjustment**

To encourage the participation of medical trainees in fields such as emergency and inpatient care, critical care/intensive care, gynecology, pediatrics surgery and general surgery, the Bureau announced 42 adjustments to fee schedules between 2004 and 2008. The most significant overhauls of the fee schedule made on June 14, 2004 and in December 2005, involved adjusting payment of 1,382 items and services.

Another round of changes was announced in December 2006 to reflect technological developments and clinical needs. Some 33 procedures and devices, including laparoscopies and thoracoscopies and incubators for newborn infants, were added to the list of items covered under the program.

Beginning January 1, 2008, payment for kidney, heart, lung and liver transplants were increased substantially. The standard fee for kidney transplants was set at three times its previous level, while the standard point value for heart, lung and liver transplants was increased to twice the existing level. Fees for outpatient care for children under two years of age were increased by 20%. The BNHI also added more than ten items to the Fee Schedule with medical advancements in 2009-2010, including Ventricular Assist System implantation, Intraoperative Microelectrode recording of basal ganglia, TRODAT-1, Tc-99m TRODAT-1 Dopamine Transporter Brain SPECT, Photodynamic therapy (PDT), Autofluorescence Bronchoscope, NaF-18PET, Cadaver Pancreas Transplant.
Balance Billing for Expensive Medical Devices

The NHI system also covers a number of newly developed technologically advanced products that provide better health benefits, even if they are many times as expensive as the medical devices they have been designed to replace. To ease the financial burden of patients who stand to benefit from such advanced products, the Bureau phased in partial coverage of drug-eluting stents, ceramic hip joints, intraocular lenses, and metal-on-metal hip joints beginning on December 1, 2006 (Table 10). For patients who choose these and other more expensive medical devices, the NHI system covers the standard fee it would pay for similar more conventional medical devices, while patients cover the additional cost.

To safeguard the rights of the insured, the Bureau requires that physicians clearly inform patients or their families why a more advanced medical device is needed and the additional amount they will be asked to pay prior to the procedure and then have them fill out the required authorization agreement.

Table 10  Balance Billing Devices Newly Covered by the NHI

<table>
<thead>
<tr>
<th>Item</th>
<th>Date of Coverage Began</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug-eluting Stents</td>
<td>Dec. 1, 2006</td>
</tr>
<tr>
<td>Ceramic Hip Joints</td>
<td>Jan. 1, 2007</td>
</tr>
<tr>
<td>Intraocular Lenses</td>
<td>Oct. 1, 2007</td>
</tr>
<tr>
<td>Metal-on-metal Hip Joints</td>
<td>May 1, 2008</td>
</tr>
</tbody>
</table>

Drug Prices Adjustment

The BNHI has followed the Pharmaceutical Benefit Scheme to adjust drug prices and narrow the gap between the actual transaction prices and the NHI listed prices. It has gradually reduced the price gap on drugs with the same active ingredients, dosage form, specifications, and that do not involve intellectual property rights or quality disputes, while also adjusting the prices paid for drugs to bring them closer to actual market prices.

The effort to rationalize drug expenditures began in 1996, when the Bureau launched a review of drug pricing and measures to adjust drug prices, and it has adopted a number of successful measures over the years that have helped it pay more reasonable prices for the medications covered by the insurance.

Profile Analysis

The BNHI has monitored and guided contracted health care institutions since 2003 based on profile analysis and evidence-based medicine. The initiative has compelled health care providers to learn and improve together, elevating the overall quality of health care.
A profile analysis is done on resource usage (such as usage rates of CT scans and MRIs), patient visit situation (such as repeat treatment rates), drug use status (such as use of antibiotics and injections, or number of items per prescription) and treatment status (such as incompletion rate of endodontic treatment) based on the health care institution, the medical specialty and type of disease. The results of the analysis are given to hospitals and clinics to guide them and help them improve.

**Auditing Health Care Institutions**

To avoid medical abuse and deter medical institutions from improperly claiming expenses, the BNHI rigorously checks for violations of payment claims guidelines. When computerized checks turn up irregularities in expense claims or a specific type of major violation, the Bureau screens its database for similar abnormal claims and sets up on-site investigations as needed to improve the quality and efficiency of the process.

If the review process discovers that a violation is severe or systematic, the Bureau sets up a special auditing taskforce to investigate. Whatever flaws are uncovered are reported to related agencies for their reference to help build a superior medical operating environment.

Health care institutions found to have violated regulations can be assessed demerits, have reimbursed expenses reduced up to 10 times, have their contracts with the Bureau suspended for one to three months, or have their contracts terminated, depending on the severity of the offense. For those contracted medical institutions and medical personnel that no intention to rectify and continue to violate regulations, as well as the medical institutions of the same address that keep violating regulations, the BNHI will suspend their contracts for 10 years. If there is substantive evidence that they violated the law, their cases will be forwarded to judicial authorities for prosecution.

**Counseling Effective in Reducing Excessive Visits**

The BNHI has its electronic medical record system trace and counsel individuals who make an excessive number of outpatient visits. The program prevents medical waste by guiding these heavy users of the health care system on how to properly seek treatment.

The guidance program has successfully reduced the excessive outpatient visits. By the end of December 2010, the average number of doctor visits for the 32,951 patients under counseling who sought treatment 100 times or more in 2009 fell by 19%.
Disclosure of Quality Information

The BNHI is committed to making health-related information more accessible and transparent to improve service efficiency and empower the public to monitor the country’s medical system. To fulfill that commitment, the Bureau created a “Virtual Private Network” (VPN), which links it to hospitals and clinics, and other Internet-based tools that provide other health-related information to the public.

Under the global budget payment system, healthcare quality indicators are determined in collaboration with each sectoral budget's payment committee, and two to three quality indicators are chosen jointly with the committee to be disclosed publicly online through the BNHI website as benchmarks for medical institutions and the public.

Further discussions will be held with these committees in the future to negotiate an increase in the number of indicators that can be made public and to study the effectiveness and feasibility of other information outlets to ensure that people have access to this information. From 2005 to 2010, 85 quality indicators were posted on the internet and had received 3,411,850 hits as of the end of December 2009.

IC Card and Online Services

The Health Insurance IC Card

Officially launched in January 2004, the health insurance IC card, issued to every insured, has improved record keeping, lowered administrative costs, and brought greater convenience to patients.

Security Features

To protect confidential information and prevent it from being counterfeited, the IC card is designed with guilloche pattern, rainbow printing, micro-text printing, optical variable ink, and UV printing. The background of the cardholder’s picture possesses anti-forgery characteristics, while the embedded microchip employs a number of verification mechanisms to protect the information it contains. Online transmission is conducted within the Bureau’s closed network, the Virtual Private Network, which is reinforced by a multi-tiered firewall to prevent information leakage.

Contents of the Health Insurance Card

The health insurance card contains basic personal information, records of recent doctor visits, preventive medical test results, and personal characteristics such as drugs to which an individual is allergic.
The health insurance card also contains a catastrophic illness code to record the card holder’s illness, the start and expiration dates of the catastrophic illness certificate.

The Bureau has also begun entering drug prescriptions and important medical tests on the cards as a reference for physicians treating the patients. Access to this information prevents the inappropriate use of medical resources, such as repetitive prescriptions or tests, and reduces examination risks and wait times for patients.

At the same time, with the IC card, records of every patient visit are uploaded to the BNHI overnight, enabling the Bureau to turn out statistics of outpatient and inpatient visits on a daily basis and help it spot and pursue irregularities as they happen.

Another special function of the IC card is that it can store Department of Health files indicating the willingness of the bearer to donate organs or receive hospice care, provided that the bearer has applied for hospice care or previously volunteered to donate organs. With this information, family members and physicians can make necessary end-of-life decision on behalf of the cardholder who has lost consciousness.

**A Powerful Online Claim System**

Since the inception of the NHI system, the Bureau has encouraged contracted health care institutions to file their expense reimbursement claims electronically (via the Internet, electronic media or the VPN), enhancing reporting efficiency and lowering the administrative costs. The system also shortens the time it takes to make reimbursement to providers’ claims. Nearly all contracted health care institutions now file their claims electronically.

The Virtual Private Network in particular was set up to provide a two-way communication channel with health care institutions, which now use it to verify and update IC cards during patient visits, file their expense claims and report clinical trial plans. Now almost all contracted health care institutions have joined the VPN systems.

The BNHI has set up other online systems to accommodate the increasing efforts of medical institutions to digitalize their operations and strengthen the overall e-government environment. In September 2006, a Picture Archiving and Communication System (PACS) to audit expense claim (including written information and images) was launched to help medical institutions electronically report their expenses. At the same time, the system was linked to the BNHI's internal payment systems, automating the claims adjudication system even further.
Efforts have been put into for a software that allows all contracted health care institutions to report their expense claims electronically through one window, the IC Card Data Center (IDC), to streamline the process even further. Health care institutions will also be encouraged to capitalize on the online systems to share image and document files of patients among themselves and prevent repeat tests and checkups, which will help reduce the health insurance system's expenditures and encourage the digitalization of the medical sector and the standardization of medical imaging.

Multifunctional Online Platform for Employers

In January 2006, the BNHI updated its general services operating system and created a “multiple authentication Internet platform,” offering diversified online services that are periodically updated and expanded. As of March 2011, more than 100 thousands of the group insurance applicants take use of the platform; by which there are around 700 thousands revisions reported each month, accounting for more than 60% of total revisions.

1. Insurance registration organizations can report newly enrolled or withdrawn insured and adjustments to their reported salaries.

2. Insurance registration organizations can download statements detailing how their bills were calculated and check previous statements.

3. Registered individuals can check if they have overdue payments and apply for a copy of the original bill; they can also see if their IC card is still valid or check on progress in getting a new card.

4. Insurance registration organizations that represent professional groups, such as labor unions and farmers' and fishermen's associations, can report collective data on overdue premium payments.

5. Registered individuals can apply to have IC cards (without photos) made and issued for newborn infants.

6. The system can be used to print bills and payment receipts and pay premiums online.

7. Insurance registration organizations can change their basic information (such as their name, address and telephone number) online.
Our NHI system’s successful experience has won global attention, with many countries interested in emulating aspects of Taiwan’s program. Every year, hundreds of experts and scholars or government representatives from abroad visit Taiwan for a better understanding of the system. Through these mutual exchanges, the Bureau has also obtained a wealth of information on the health care systems of other countries, which has provided a reference for local reform initiatives.

A number of international media have even taken close-up looks at Taiwan’s experience in recent years, reporting the country’s health care achievements and commending it as an example other countries can learn from. As for those countries that are interested in studying the Taiwan experience, the BNHI is able to provide technical assistance and advice while maintaining frequent exchanges to disseminate Taiwan’s experience abroad.

Described by the global media as a "A Role Model for Health Insurance" and a "Health Utopia," the NHI system has proved that this social safety net is one of the country's most precious assets.

Reports on Taiwan’s NHI

News Reports

• Nobel Laureate and New York Times columnist Paul Krugman praised Taiwan’s health care system in a November 7, 2005 column called "Pride, Prejudice, Insurance," writing that Taiwan had expanded coverage without a major increase in health expenditures.
• In a piece called "A New Zealander's View of Taiwan's National Health Insurance," journalist Mike Crean writes that New Zealanders admire Taiwan's health care scheme and achievements such as its commitment to delivering quality care to all its citizens, its fairness in financial burdens and the cooperation of the citizens, which make the system possible.

• In a special report: "Health care in Taiwan: what can the can the U.S. learn from one of the world's best systems? Plenty" of the Globalpost, journalist, Jonathan Adams, describes Taiwan's NHI and concluded that perhaps it is time for the US to listen to Taiwan.

**Journals**

• An editorial in the U.S.-based Annals of International Medicine in early 2008, titled "Learning from Taiwan: Experience with Universal Health Insurance," summarized a paper by Wen Chi-pang, a researcher with the National Health Research Institute, and others who evaluated the NHI program's first 10 years. The paper concluded that Taiwan's health care policies had helped improve the life expectancies of socially disadvantaged groups and narrowed the disparity in care between the wealthy and the poor.

• In a column, titled "Humbled in Taiwan," in the British Medical Journal (BMJ) in January 2008, noted health care economist Uwe Reinhardt stressed the high administrative efficiency of Taiwan's health insurance system. He suggested that the United States should be inspired by Taiwan's experience.

• An article in the winter 2008 edition of U.S. political magazine "Dissent" called "Health Care in Taiwan: Why Can't the United States Learn Some Lessons?" introduced Taiwan's health care system and stressed that the single-payer, government-administered system that Americans so fear has not led to abuses in Taiwan's health care system.

• The May 2003 edition of Health Affairs featured two articles on Taiwan's health insurance program and its impact on keeping health care costs under control. Both papers highly praised the achievements of Taiwan's health care system, especially its universal coverage, wide range of coverage, high level of access, short waiting times and low administrative costs. They also highlighted the system's low premiums, the high level of care and the public's consistently high level of satisfaction with the program, all attributes, the studies said, worthy of emulation by other countries.
TV Programs

• In 2008, Taiwan was also featured in one of the U.S. Public Broadcasting Service’s (PBS) Frontline series called "Sick around the World," which focused on the health insurance systems of Taiwan, Britain, Germany Switzerland and Japan. The report on Taiwan's health care system explored and praised the range of Western medicine, dental, traditional Chinese medicine and mental illness services offered, as well as the adoption of the IC card, the payment of fees directly to health care institutions and a cost of care less than half that in the United States. The series compared Taiwan to other advanced countries and brought considerable international attention to the country’s health insurance system.

• In 2003, ABC News broadcast a report on Taiwan's universal health care system, stressing how the program offers care to all of Taiwan's people, after years in which 40% of the population was left uninsured.

Taiwan's Healthcare System in Comparative Perspective

Taiwan’s NHI system has attracted the attention from around the world for its many achievements, including its universality, ability to care for socially and economically disadvantaged groups, wide range of coverage and consistent level of quality. Below is a series of charts that provide a comparison of Taiwan's health care indicators with those from other countries around the world.

Figure 8  Selected Countries’ Health Care Expenditures Comparison, 2008

Source: OECD Health Data, Taiwan Health Statistics
High Satisfaction Rating

The NHI system faced considerable challenges and resistance when it was first put in place, and public satisfaction with the program at its inception stood at below 40%. Today, nearly 80% of local residents are satisfied with the system, a reflection of the public's recognition of the Bureau's efforts over the past 15 years. Although the system's satisfaction rating plummeted in 2002 when premiums and copayments were raised, it quickly recovered to 77% a year later and has remained near 80% the past two years (Figure 10).

Figure 9  Annual Growth Rate of Medical Expenditures in Selected Countries from 1999 to 2008

Source: OECD Health Data 2010 Taiwan Health Statistics

Figure 10  NHI Public Satisfaction Ratings

Source: OECD Health Data, Taiwan Health Statistics
Background Information

The purpose for implementing the National Health Insurance (NHI) program is to ensure that the entire population is covered by the social insurance system and that everyone receives appropriate medical care. The ultimate goal is to prevent any delays or failures in receiving medical care that may be caused by financial hardships.

Because of rapid increases in NHI medical expenses, the NHI program is facing a financial imbalance. The increases in expenses have been caused by many factors, including rapid population aging, a dramatic increase in the number of patients suffering from catastrophic diseases, and the continuous introduction of new medical technologies, pharmaceutical products and medical devices. Focusing on the various problems of the first-generation NHI, the government has proposed the "Second-Generation NHI" reform, endeavoring to better
satisfy the demands of the population and to better accommodate the practical requirements of the program. In the past few years, more than a hundred scholars participated in the research and discussion process and conducted comprehensive review on various issues including a structured accountability system for NHI, fairness in financial contributions, assurance of medical treatment quality and encouraging greater participation by society, etc. They’ve also developed forward-looking plans for reformation and proposed feasible recommendations. Based on these recommendations, the government subsequently completed the draft of the amended National Health Insurance Act, which was passed by the Legislative Yuan on January 4, 2011 and promulgated by the President on January 26, 2011. The date for formal implementation of the Second-Generation NHI will be decided and announced by the Executive Yuan separately.

What are the key reforms that will benefit the general public?

**Key Reforms of the NHI**

**Expanding the Basis for NHI Premium Calculation and Reinforcing the principle of Ability to Pay**

Under the existing NHI program, the premium is calculated on the basis of the participant’s salary. Income that does not come from a salary is not included in the calculation. People who receive a salary as their primary source of income, therefore, are shouldering more of the burden of premium payments than people with diversified income sources. The purpose for imposing a supplementary premium directed at irregular income sources is to reinforce the spirit of “Ability to Pay” and improve the fairness of the NHI program. The approach will also lead to a slight reduction of the existing premium rate and narrow the difference in premium contributions among people with similar income levels, thereby ensuring a fairer and more reasonable income contribution system.

A supplementary premium will be levied for the following six items:

1. Bonus/cash rewards with an accumulated amount per year that exceeds four times the insured monthly salary.
2. Income from professional practices
3. Stock dividends
4. Interest income
5. Rental income
6. Income from part-time jobs

Furthermore, a 2% supplementary premium shall be directed at employers (the insurance registration organization) based on the difference between the total monthly salary expenses and the total insured monthly salary for employees. This approach not only helps to balance the premium contribution level among employers, but also ensures a more reasonable premium contribution from the insurance registration organizations who have adopted a "Low base salary; high bonus" compensation system.
The premium burden will be reduced for the majority of people who are receiving income from a single source.

**Simulation Case 1:**

Mr. Chang is a single office worker with an insured monthly salary of NT$53,000. He is also receiving a year-end bonus equivalent to 2.5 times of his monthly salary.

**Calculation method:**

First-Generation NHI: $53,000 \times \text{Premium Rate 5.17\%} \times \text{Contribution Ratio 30\%} = \text{NT$822}$

First-Generation NHI: $53,000 \times \text{Premium Rate 4.91\%} \times \text{Contribution Ratio 30\%} = \text{NT$781}$

After the implementation of the second-generation NHI, Mr. Chang will save NT$41 each month, or NT$492 per year.

**Explanation:**

In the future, assuming the premium rate is 4.91\%, Mr. Chang, as an employee, will be required to cover 30\% of the NHI premium. Since the amount of his year-end bonus does not exceed four times his monthly salary, there is no need for him to pay a supplementary premium.

**Simulation Case 2:**

Mr. and Mrs. Chen are insured with NHI at NT$50,600 and NT$42,000 respectively. They are both receiving a year-end bonus equivalent to 2 times of their monthly salary. Their two kids are also insured with NHI through Mrs. Chen's employer.

**Calculation method:**

First-Generation NHI: $(50,600 \times \text{Premium Rate 5.17\%} \times \text{Contribution Rate 30\%}) + (42,000 \times \text{Premium Rate 5.17\%} \times \text{Contribution Rate 30\%} \times 3\text{ participants}) = \text{NT$2,739}$

First-Generation NHI: $(50,600 \times \text{Premium Rate 4.91\%} \times \text{Contribution Rate 30\%}) + (42,000 \times \text{Premium Rate 4.91\%} \times \text{Contribution Rate 30\%} \times 3\text{ participants}) = \text{NT$2,601}$

After the implementation of the second-generation NHI, the four-member Chen household will save NT$138 each month, or NT$1,656 per year.

**Explanation:**

In the future, assuming the premium rate is 4.91\%, Mr. and Mrs. Chen, as employees, will both be required to cover 30\% of the NHI premium. Since the amount of their year-end bonuses do not exceed four times of their monthly salary, there is no need for them to pay a supplementary premium.
Investing in national health by introducing diversified methodologies for premium calculation payment

In terms of the medical benefits, the principle of payment for the second-generation NHI is that equal benefits shall be offered to people in the same diagnosis-related group or receiving the same quality of medical care. The insurer will also conduct a "Capitation Payment" pilot program, i.e., hospitals and clinics within the same geographic area will work as a community medical group. NHI participants will be encouraged, but not restricted, to receive medical care in the same medical group. The community medical group, on the other hand, is expected to maintain close interactions with the patients by providing preventive health services, health education, as well as individual case management. The objectives are to provide integrated and high-quality medical services based on a "patient-centered" philosophy. The monetary savings will be paid back to the medical institutions.

Increasing counseling and supervision to decrease waste of medical resources

The second-generation NHI will impose heavier penalties against hospitals or physicians making fraudulent claims. A permanent suspension of the NHI contract will be enforced in cases of severe violations. In cases where an insured person seeks medical care frequently or repeatedly, resulting in a waste of medical resources, the Bureau of National Health Insurance (BNHI) shall provide necessary guidance and assistance. No NHI benefits will be granted if the insured person fails to seek medical assistance from the hospitals/clinics designated by the BNHI.

Ensuring the transparency of information and encouraging participation by the general public

After the implementation of the second-generation NHI, people will be able to access various NHI-related information through the internet, including premium rates, scope of benefits, insurance benefits for medical services and pharmaceutical products, ratios and numbers of insured beds in NHI contracted hospitals, health education information, information concerning severe violations, etc. The new approach will help NHI participants to select appropriate hospitals, physicians and therapies.

Reducing the copayments of the disadvantaged

In order to safeguard the interests of the disadvantaged, the second-generation NHI has rectified the weaknesses of the first-generation NHI, and retained the items that are favorable to this population sub-group. Special efforts have been made in providing "Proactive support". For example, suspension of NHI benefits coverage shall not apply to people with financial hardships or victims of domestic violence who are currently covered by protection orders issued by the court. Exemption or reduction of copayments shall be granted to participants residing in areas with shortage of medical resources. The copayment for home nursing services shall be reduced from the current 10% to 5%.

Enforcing stricter restrictions on the access to NHI benefits by individuals who have stayed overseas for a long period of time

Many people who have been living abroad for long periods of time and suspended the NHI coverage, once they have diseases, they will return to Taiwan to enroll in the NHI program again for enjoying the coverage. Under the second-generation NHI, access to NHI will only be allowed when the applicant has an "insurance enrollment record within the past two years," or has held a household registration in Taiwan for more than six months. The purpose of this reform is to resolve the unfairness of this issue.
Future Challenges

The BNHI's efforts for more than a decade have clearly rewritten Taiwan's health care history. But as demands on the system continue to grow, the Bureau must strengthen the efficiency of its services and tighten up its operations if it is to sustain Taiwan's health care quality and safeguard the rights of citizens to health care.

The Bureau will remain dedicated to reducing the financial burden of health care, caring for people's health and promoting social equality as it initiates reforms to better satisfy every patient's needs and provide superior medical services. Future policy objectives and strategies are described below.

Realizing Social Justice

Prioritizing Acute and Critical Care for the Disadvantaged

Ensuring that patients with catastrophic illnesses get the care they are entitled to is one of the BNHI's top priorities. The NHI scheme provides economically disadvantaged persons having serious conditions with relief loans and installment plans to ease their financial burden, following they hold a certificate of low-income status obtained from their borough office or health care institutions.

Improving Access to Quality Care in Remote Regions

The Integrated Delivery Service (IDS) program will continue to provide on-site outpatient and emergency care and transfer services in remote areas as it institutionalizes integrated regional medical care. Efforts are underway to promote health consciousness, nutritious diet and preventive medicine for indigenous peoples, improve the functioning of the referral system, build a common health care information system for all remote areas, and elevate the overall care of Taiwan's indigenous peoples.

Expanding Resources to Care for Disadvantaged

The BNHI will strengthen measures to assist those who are unable to pay their premiums. Measures include: providing interest-free loans to cover premiums or medical expenses; helping those in need get financial assistance from charitable groups or private sponsors; offering installment payment plans; and raising funds from new sources. These initiatives will help ensure that financial obstacles will not limit impoverished households' access to health care.
Improved Payment Efficiency
Global Payment System in Tune with Health Care System Development

At present, payments to health care providers are made on a fee-for-service basis within a global budget assigned to specific medical sectors, but a "pay-for-performance" system has been introduced gradually to improve health care quality. To preserve the effectiveness of the global budget payment program, the BNHI and health care providers have initiated a quality assurance program to monitor medical institutions that use global budgeting and to provide health care services at a higher quality level. The goal is to ensure that people's health care needs are met under the global budget payment scheme by improving care while keeping cost growth under control.

Flexible Financial Management
Making both Ends Meet

The amended National Health Insurance Act was promulgated by the President on January 26, 2011, signifying an important reform of the first-generation NHI program which has been in implementation for 16 years. The purpose of the amendment is to ensure greater fairness in the premium rate, basis for premium calculation, and methodologies for determining premiums. It is anticipated that the 2nd Generation National Health Insurance Reform can help expand the funding base for the National Health Insurance system and making the sharing of the financial burden imposed by the system fairer and more equitable. Furthermore, the amendment will also serve to safeguard the rights and interests of the NHI participants in receiving medical care, protect the health of the population, and improve the quality of medical services.

Improving Quality of Care
A Sustainable System Based on Quality, Equity and Efficiency

The BNHI is committed to preserving its system of partial coverage of medical expenses, providing patients with more treatment options and encouraging health care providers to make information on their services more transparent. The Bureau has developed an online services platform that compiles available treatment quality information and provides the public with clinical care guidelines, while also adding a consulting service function allowing individuals to search for their own information to better understand their insurance and treatment status. This electronic system has empowered individuals to manage their own health and elevate the overall quality of outpatient visits.

Achieving a National Consensus

Taiwan’s NHI may be facing a multitude of challenges in the near future, but the BNHI will remain devoted to improving the quality of medical care in the country, rationalizing and stabilizing the health insurance system's structural and financial pillars and advancing social justice. The Bureau will work even harder in the future to further encourage social equity, improve service efficiency and forge a social consensus on the health care system so that the quality of care improves for all Taiwanese citizens and the insurance program can be sustained into the future.
Appendix: The National Health Insurance Act

First Promulgated on August 9, 1994 by the President’s Order of Hua Chung (1) Yi Tze No.4505
Amended and Promulgated Articles 11-1, 69-1 and 87 by the President’s Order of Hua Chung (1) Yi Tze No.5865 on October 3, 1994
Second Amendment and Promulgation of Articles 8 to12, 14, 19, 24, 26, 30, 32, 36, 69, 88 and the Addition of Articles 87-1 to 87-3 by the President’s Order of Hua Chung (1) Yi Tze No.8800162120 on July 15, 1999
Third Amendment and Promulgation of Articles 8, 9, 11, 13, 14, 18, 19, 21, 22, 24, 25, and 27-29 by the President’s Order of Hua Chung (1) Yi Tze No. 9000014910 on January 30, 2001
Fourth Amendment and Promulgation of Articles 21, 27, 29, 32, 55, 87-1, 87-2, and the Addition of Article 22-1 by the President’s Order of Hua Chung (1) Yi Tze No. 09100142270 on July 17, 2002
Fifth Amendment and Promulgation of Articles 30, 87-1-87-3, and the Addition of Articles 87-4 and 87-5 by the President’s Order of Hua Chung (1) Yi Tze No. 09200113970 on June 18, 2003
Sixth Amendment and Promulgation of Articles 64 and 82 by the President’s Order of Hua Chung (1) Yi Tze No. 09400072571 on May 18, 2005
Seventh Amendment and Promulgation of Articles 24 and 83 by the President’s Order of Hua Chung (1) Yi Tze No. 09900019971 on January 27, 2010
Amendment of the National Heath Insurance Act by the President’s Order of Hua Chung (1) Yi Tze No. 10000111861 on January 26, 2011
Amendment and Promulgation of Articles 11 of the National Health Insurance Act by the President’s Order of Hua Chung (1) Yi Tze No. 10000132401 on June 29, 2011
Chapter 1 General Principles

Article 1
This Act is enacted to promote the health of all nationals, to administer national health insurance (hereinafter referred to as “this Insurance”) and to provide health services.

This Insurance is compulsory social insurance. Benefits shall be provided during the insured term under the provisions of this Act, in case of illness, injury, or maternity occurred to the beneficiary.

Article 2
Terms used in this Act are defined as follows:

1. Beneficiary: refers to the insured and his/her dependents.

2. Dependents:
   (1) The insured’s spouse who is not employed.
   (2) The insured’s lineal blood ascendants who are not employed.
   (3) The insured’s lineal blood descendants within second degree of relationship who are either under twenty years of age and not employed, or are over twenty years of age but incapable of making a living, including those who are in school without employment.

3. Premium withholder: Refers to the individual from whom premium is withheld according to the Taxation Law.


5. Insurance budget: Refers to the insurance benefit expenditures and reserve funds that should be established or added.

6. Medical Visit Advice: Refers to understanding the insured’s medical visit practices, providing appropriate medical and health education, and arrangement and assistance of medical visit when the insured has been found to duplicate medical visits, undergo repetitive visits, and use inappropriate treatment.

Article 3
The government should at least shoulder 36 percent of the remainder of the annual insurance budget minus promulgated revenues.

According to law, the government should include in the budget 36 percent of the deficit remainder of the annual insurance budget minus promulgated revenues, wherein the Competent Authority shall draw up a budget to cover the deficit.

Article 4
The Competent Authority of this Insurance shall be the Department of Health, Executive Yuan.

Article 5
The Supervisory Board of the National Health Insurance (hereinafter referred to as this “Board”) shall be in charge of the following tasks:

1. Review of premiums;

2. Review of the scope of benefits;

3. Coordination of drafting and allocation of medical benefit payments;

4. Study and interpretation of insurance laws and policies;

5. Other supervisory functions pertaining to the insurance matters.
When the review and coordination done by the Board in the previous paragraph find a reduction in insurance revenues or increase in insurance expenditures, it should as the Insurer to present a proposal for resource allocation and financial balance to reviewed or coordinated jointly.

When the Board reviews and coordinates matters relevant to the Insurances, it should make public its agenda seven days before the meeting and the meeting minutes within ten days after the meeting. Before reviewing and coordinating major matters, it should gather information on public opinion and if necessary, organize related activities involving the public.

The Board is made up of the insured, employers, insurance medical service providers, experts, reputable public figures, and representatives from relevant agencies. Representatives from premium payers should not be less than one-half of the total number of board members, while representatives from the beneficiaries should not be less than one-third.

The Competent Authority shall determine the number of members, how they are selected, meeting regulations, self-disclosure of representative’s interest, and disclosure to the public.

Matters reviewed and coordinated by the Board should be approved by the Competent Authority or presented to the Executive Yuan for approval. Matters approved by the Executive Yuan should be sent to the Legislative Yuan for future reference.

Article 6

The insured, the group insurance applicants, premium withholder, and the contracted medical institutions should apply for a review to settle disputes against the Insurer. They may file administrative appeal and administrative lawsuit if they disagree with the review results.

The National Health Insurance Disputes Settlement Board shall perform the task of reviewing such disputes.

The Competent Authority shall determine the scope of the abovementioned disputes, application for review or deadline for submission of documents, procedures, as well as the review methods and process.

Chapter 2 The Insurer, The Beneficiary, and The Group Insurance Applicant

Article 7

The Insurer of this Insurance shall be the Bureau of National Health Insurance of the Department of Health, Executive Yuan, which will administer the insurance business.

Article 8

Any national of the Republic of China must meet one of the following requirements in order to become the beneficiaries of this Insurance:

1. Those who have previously subscribed to this Insurance within the last two years and have a registered domicile in Taiwan, or having established a registered domicile for at least six consecutive months in the Taiwan area prior to subscription of this Insurance;

2. The following individuals who have established a registered domicile in the Taiwan area at the time of becoming a subscriber:

   (1) Civil servants or full-time and regularly paid personnel in governmental agencies and public/private schools;

   (2) Employees of publicly or privately owned enterprises or institutions;
(3) Employees other than the insured prescribed in the preceding two items;
(4) Newborns in the Taiwan area;
(5) Spouse and offspring of government officials assigned abroad.

Individuals who have previously subscribed to this Insurance and have gone abroad before this revision was promulgated on January 4, 2011 should immediately establish residency and subscribed to this Insurance the first time they return to the country one year after the revision has been implemented. They will not be subject to the six-month restriction of subparagraph 1 of the previous paragraph.

Article 9
With the exception of individuals mentioned in the previous article, any national of the Republic of China must meet one of the following requirements in order to become the beneficiaries of this Insurance:

1. Those who have established a registered domicile for at least six consecutive months;
2. Those with a regular employer.

Article 10
The insured shall be classified into the following six categories:

1. Category 1
(1) Civil servants or full-time and regularly paid personnel in governmental agencies and public/private schools;
(2) Employees of publicly or privately owned enterprises or institutions;
(3) Employees other than the insured prescribed in the preceding two items but are otherwise employed by particular employers;
(4) Employers or self-employed owners of business;
(5) Independently practicing professionals and technicians.

2. Category 2
(1) Members of an occupational union who have no particular employers, or who are self-employed;
(2) Seamen serving on foreign vessels, who are members of the National Seamen’s Union or the Master Mariners’ Association.

3. Category 3
(1) Members of the Farmers’ Association or the Irrigation Association, or workers aged over fifteen who are actually engaged in agricultural activities;
(2) Class A members of the Fishers Association who are either self-employed or have no particular employers, or workers aged over fifteen who are actually engaged in fishery activities.

4. Category 4
(1) Military servicemen whose compulsory service terms are over two months or who are summoned to serve in military for more than two months, military school students who receive grants from the government, military servicemen’s dependents who lost their support recognized by the Ministry of Defense, and military decedent’s families who are receiving pensions due to the death of their decedents.
(2) Men at age for enlisting in the military, who are currently in military-substitute service.
(3) Those who are serving sentences in correctional institutions or receiving punishments from police and military court-martial. However, this is not applicable to those who are serving sentences of less than two months or are under parole.

Appendix: The NHI Act
5. Category 5
Members of a household of low-income families as defined by the Social Support Law

6. Category 6
(1) Veterans, household representatives of survivors of veterans;
(2) Representatives or heads of household other than the insured or their dependents prescribed in subparagraphs 1 to 5 and the preceding item of this subparagraph.

The standard for identification and qualification of the workers actually engaged in agricultural activities under item (1) of subparagraph 3 and the workers actually engaged in fishery activities under item (2) of subparagraph 3 shall be established jointly by the central agricultural competent authority and the Competent Authority.

Article 11
The insured classified in Category 1 may not opt for classification in Category 2 or Category 3. The insured classified in Category 2 may not opt for classification in Category 3. The insured classified in Categories 1 to 3 may not opt for classification in Category 4 to 6. However, Class A members of the Fishers Association who hire 10 or less laborers for ocean fishing and are actually engaged in fishery activities starting from January 21, 2002, should be classified as Category 3.

Those who qualified as the insured shall not subscribe to this Insurance as dependents.

Article 12
The dependents of the insured in Article 2 shall subscribe to or withdraw from this Insurance together with the insured. However, this rule shall be inapplicable to situations including but not limited to domestic abuse, which are recognized by the Competent Authority as difficult for dependents to subscribe to or withdraw from this Insurance together with the insured.

Article 13
The following persons are not covered by this Insurance and shall be withdrawn from it if they have subscribed to this Insurance:
1. Those who have been missing for six months or more;
2. Those who are not qualified under Articles 8 or 9.

Article 14
The commencement of the insurance shall take effect from the date of occurrence of such qualifications specified in Articles 8 or 9.

The termination of the insurance shall take effect from the date of occurrence of the previous article.

Article 15
The group insurance applicants for the different Categories of the insured are as follows:
1. For the insured in Categories 1 and 2, the group insurance applicants shall be the agencies, schools, enterprises, institutions, or employers, which they work for, or unions where they hold membership. Nonetheless, the group insurance applicants that cover the insured in the Ministry of Defense shall be designated by the Ministry of Defense.
2. For the insured in Category 3, the group insurance applicants shall be the lowest-level Farmers Association, Irrigation Association or Fishers Association to which they belong, or located at the place where the insured have their household registered.
3. For the insured in Category 3, the group insurance applicants are as follows:
(1) For the insured in item 1, subparagraph 4, paragraph 1, article 10, the group insurance applicants shall be designated by the Ministry of Defense.

(2) For the insured in item 2, subparagraph 4, paragraph 1, article 10, the group insurance applicants shall be designated by the Ministry of Interior.

(3) For the insured in item 3, subparagraph 4, paragraph 1, article 10, the group insurance applicants shall be designated by the Ministry of Justice and by the Ministry of Defense.

4. For the insured in Categories 5 and 6, the group insurance applicants shall be the village (township, municipal, district) administration offices of their registered domiciles; provided, however, the public or private social welfare service institutions may be the group insurance applicants for the insured who lives therein.

The insured prescribed in item 2, subparagraph 6, paragraph 1 of Article 10, and their dependents may, upon consent of the group insurance applicants of the insured in another category who live together with the above insured and their dependents, use such units as their group insurance applicants for the insured who lives therein.

The group insurance applicant has failed to make the premium payments for more than two months, the Insurer may contact another group insurances applicant to administer matters related to this Insurance.

The group insurance applicants shall subscribe to the Insurer for coverage within three days from the date on which the beneficiaries meet the conditions of this Insurance and shall withdraw from the coverage within three days from the date of occurrence of the cause of the withdrawal.

Article 16

The Insurer must produce and distribute a national health insurance card with electronic information processing function to store and send information on the insured. However, the card may not store any information not used for medical care purposes as well as those unrelated to the insured receiving insurance medical services.

The Insurer shall charge a fee for changing or replacing the abovementioned card; it shall also determine the production, replacement, changing, type and use of stored and sent information, management of the card's use as well as other relevant matters, which shall be announced after being approved by the Competent Authority.

Chapter 3 Insurance Finance

Article 17

The Central Government, the group insurance applicant, and the insured shall jointly shoulder the insurance budget after promulgated revenues have been deducted.
Article 18

The premium payable by the insured in Categories 1 to 3 and their dependents shall be calculated according to the insured payroll-related amount and the premium rate of the insured. The premium rate shall be set a maximum of 6 percent.

The premium payable by the dependents articulated in the previous paragraph shall be paid by the insured. When the number of dependents exceeds three, the premium shall be calculated on the basis of only three dependents.

Article 19

The insured payroll-related amount for the insured in Categories 1 to 3 shall be subject to a grading table drafted by the Competent Authority and be reported to the Executive Yuan for approval.

The minimum in the said Grading Table of insured payroll-related amount shall be equal to the base salary promulgated by the central competent authority in charge of labor affairs. Upon adjustment of the base salary, such minimum shall be adjusted accordingly.

The insured payroll-related amount of the top level of the Grading Table of insured payroll-related amount has to be kept fivefold higher than the amount in the bottom level, and the said Grading Table has to be revised in one month after the basic salary is adjusted. In case that the number of the insured applicable to the highest level of insured payroll-related amount exceeds three percent of the total number of the insured for twelve consecutive months, the Competent authority shall readjust the Grading table of the insured payroll-related amount to advance a higher level starting from the following month.

Article 20

The insured payroll-related amount for the insured in Categories 1 and 2 is determined on the following basis:

1. Employees: the payroll;
2. Employers and self-employed: the business income;
3. Self-employed individuals and independently practicing professionals and technicians: the income from professional practice.

If the insured prescribed in Categories 1 and 2, has no stable income, the insured shall select the proper insured payroll-related amount from the Grading Table of insured payroll-related amount and such insured payroll-related amount shall be examined by the Insurer, who may make adjustment at its own discretion if the insured payroll-related amount is found inappropriate.

Article 21

In case that the income of the insured in Categories 1 and 2 as prescribed in the previous article is adjusted between February and July of the current year, the group insurance applicants shall notify the Insurer the adjusted insured payroll-related amount by the end of August of the same year, or notify the Insurer by the end of February of the following year if the adjustment is made between August of the current year and January of the following year, which shall become effective on the first day of the following month after notification.

Unless the insured payroll-related amount as prescribed in the preceding paragraph has reached the highest level of this Insurance, such amount shall not be lower than the monthly labor pension reserve deposit or the insured salary.
of other social insurance schemes to which the insured subscribes. In case that the insured payroll-related amount of this Insurance is lower, the group insurance applicant shall at the same time notify the Insurer to adjust accordingly, or the Insurer may also make adjustment at its own discretion.

Article 22
The insured payroll-related amount applicable to the insured in Category 3 shall be the average amount for those specified under items 2, 3 of subparagraph 1, and subparagraph 2 of paragraph 1, Article 10; provided, that the Insurer may adjust the level of insured payroll-related amount according to the financial viability of the insured and their dependents.

Article 23
The premium of the beneficiaries in Categories 4 to 6 shall be calculated according to the averaged actuarial premium based on the total number of the beneficiaries in accordance with Article 18.

The premium of the dependents stated in the previous paragraph shall be paid by the insured. When the number of the dependents exceeds 3, the payment shall be calculated on the basis of only three dependents.

Article 24
The Insurer should apply for a review one month after the premium rate of beneficiaries and each dependent in Article 18 is determined in a Board meeting coordinating the total amount of medical benefit payments. However, when premiums using the maximum rate are unable to balance with the medical benefit payments approved for that year, there should be new negotiations regarding the total amount of medical benefit payments.

Before the review from the previous paragraph, the Board should invite actuaries, insurance and finance experts, economists, and reputable public figures to provide opinions.

The review of Paragraph 1 should draft the total amount of medical benefit payments in accordance with the negotiations one month before the start of the year, completing the review of balance of payment rates. This shall be reported to the Competent Authority, which will in turn report to the Executive Yuan for approval before announcing it publicly. If review cannot be completed within the specified time, the Competent Authority shall report this matter to the Executive Yuan for approval before public announcement.

Article 25
The Insurer shall make the actuarial process at least once every five years for the premium finance, with each such actuarial process covering a period of 25 years.

Article 26
Upon the occurrence of any of the following events in this Insurance, the Insurer shall readjust the premium rate and present it to the Board which shall report it to the Competent Authority and then to the Executive Yuan for approval, after which the Competent Authority shall make the public announcement:

1. The reserve fund of this Insurance drops below total insurance benefit amount for a month.
2. Any addition to or reduction in benefit items, contents or payment schedules that affects the financial balance of this Insurance.
Chapter 4 Collection and Calculation of Premiums

Article 27

This Insurance contribution rates shall be calculated according to the following provisions of Articles 18 and 23:

1. For the insured in Category 1:
   (1) The insured and their dependents referred to item 1, subparagraph 1, paragraph 1 of Article 10 shall pay 30 percent of the premium, with the other 70 percent of it paid by the group insurance applicants. Nonetheless, for the premiums charged for the employees of private schools, the insured and their dependents shall pay 30 percent of the premiums, with 35 percent of them paid by their schools; the remaining 35 percent shall be subsidized by the central government.
   (2) The insured and their dependents referred to in items 2 and 3 of subparagraph 1, paragraph 1 of Article 10 pay 30 percent of the premiums, the group insurance applicants pay 60 percent of them, and the remaining 10 percent shall be subsidized by the central government.
   (3) The insured and their dependents referred to in items 4 and 5 of subparagraph 1, paragraph 1 of Article 10 shall pay the full premium.

2. The insured and their dependents in Category 2 pay 60 percent of the premiums, with the other 40 percent subsidized by the central government.

3. The insured and their dependents in Category 3 pay 30 percent of the premiums, with the other 70 percent subsidized by the central government.

4. For the insured in Category 4:
   (1) For the insured in item 1, subparagraph 4, paragraph 1 of Article 10, the institutions they belong shall subsidize their premiums in full.
   (2) For the insured in item 2, subparagraph 4, paragraph 1, Article 10, the central military training administrative authority shall subsidize the premium in full.
   (3) For the insured in item 3, subparagraph 4, paragraph 1 of Article 10, the central correctional authority and the Ministry of Defense shall subsidize the premium in full.

5. For the insured in Category 5, the central competent authority in charge of social welfare shall subsidize the premium in full.

6. The premium payable by the insured referred to in item 1, subparagraph 6, paragraph 1 of Article 10 shall be subsidized by the Veterans Affairs Commission, Executive Yuan.

Whereas 30 percent of the premium of the insured dependents shall be self-covered and 70 percent subsidized by the Veterans Affairs Commission, Executive Yuan.

7. The insured and their dependents referred to in item 2, subparagraph 6, paragraph 1 of Article 10, shall pay 60 percent of the premium and the central government shall subsidize 40 percent.

Article 28

Before the promulgation of this amendment on January 4, 2011, every level of government, which has been unable to appropriate funds to pay the Insurer in accordance with Article 29 (pre-amendment), should present a payback plan to the Insurer. Timeframe for the payback should not exceed eight years and Insurer shall request interest payments in accordance with Article 30 (pre-amendment).
Article 29

The number of dependents in items 1 to 3 of Category 1, for whom the group insurance applicants or the government subsidize premium, shall be the average number of the dependents that the insured in items 1 to 3 of Category 1 actually have.

Article 30

The premium of this Insurance shall be paid monthly according to the following provisions in Articles 18 and 23:

1. The premium to be contributed by the insured in Categories 1 shall be deducted from the pay roll and paid by the group insurance applicants to the Insurer, together with the group insurance applicant’s contributions, by the end of the following month.

2. The premium to be contributed by the insured in Categories 2, 3 and 6 shall be paid monthly to the group insurance applicants to which they belong, and the group insurance applicants shall forward the accumulated premiums to the Insurer no later than the end of the following month.

3. The premium payable by the insured in Category 5 shall be paid by the central competent authority regarding social welfare to the Insurer no later than the fifth day of the current month.

4. For the insured in Categories 1 to 4 and 6, the premiums shall be partly subsidized by the various levels of governments and shall be paid in advance to the Insurer twice a year by the end of January and of July. The account shall be settled at the end of the year.

The premium of the Insurance for the month in the previous paragraph when the insured subscribes to coverage shall be fully paid; and that for the month when the insured withdraw from coverage shall be exempted.

Article 31

The insured belonging to Categories 1 to 4 and 6 should pay supplementary insurance premium based on the supplementary insurance rate according to law, which shall be deducted by the premium withholder upon payment and given to the Insurer before the end of the month after payment. However, single benefit payments in excess of ten million as well as those not reaching a certain amount are exempted from deductions:

1. Accumulated annual bonus given by group insurance applicant in excess of four times the monthly premium ratable wages.

2. Salary earnings outside of those from the group insurance applicant. However, this is not applicable for the salary earnings of Category 2 individuals.

3. Income from professional practice; however income from professional practice designated by Article 20 as insured payroll-related amount is not to be included in the calculation of premium ratable wages;

4. Stock earnings; however this is not applicable to premium already included in the premium ratable wages;

5. Interest earnings;

6. Earnings from rentals.

The premium withholder shall pay first if he is unable to deduct within the specified time.
The Competent Authority shall determine the amount referred to in Paragraph 1, the method of deduction and payment of supplementary premium, as well as other relevant matters.

Article 32
Those who are not eligible, who have lost their eligibility, or who are deemed as not requiring premium withholder to deduct supplementary premium should notify premium withholder prior to receiving benefit payments so that no supplementary premium will be deducted.

Article 33
The supplementary premium rates of Article 31 shall be calculated at 2 percent one year after the implementation of the amendment of the Act on January 4, 2011. On the second year, it should be adjusted in accordance with the growth rate of the insurance premium rate, which shall be announced by the Competent Authority.

Article 34
For the group insurance applicant of items 1 to 3 of Category 1, when the total amount of salary paid exceeds the insured payroll-related amount for that month, supplementary premium should be calculated based on the difference as well as the rate in the previous article and paid jointly per month in accordance with payment structure in Article 27.

Article 35
A grace period of fifteen days shall be allowed in case that the group insurance applicants, the insured, or the premium withholder do not pay the premium during the period provided in this Act. If payment is not made by the end of the grace period, an overdue charge of 0.1 percent of the amount payable shall be levied for each day of delay after the expiry day of the said grace period until the premium is fully paid up with the maximum amounts as follows:

1.15 percent of the payment to be made by the group insurance applicant and premium withholder.

2.5 percent of the payment to be made by the insured.

The overdue charge mentioned in the previous paragraph may be waived if it is less than the amount to be fixed by the Competent Authority.

If the premium and the overdue charge referred to in Paragraph 1 payable by the group insurance applicant/premium withholder remains unpaid for thirty days, the Insurer may refer the case to the court for compulsory execution under the law; the same shall apply to the insured [who has failed to pay either the premium or the overdue charge] for one hundred and fifty days.

Article 36
Those who are unable to pay the premium, overdue charge, or full self-covered premium due to economic difficulties should apply for installment payments with the Insurer or apply for loans or subsidies according to Article 99. The Insurer should provide assistance and, if necessary, work with social agencies or relevant private professional groups to look for assistance within the society.

The Insurer shall determine the conditions of applications, review procedures, installment payment schedule, and other relevant matters in the previous paragraph and report to the Competent Authority for approval and announcement.
Article 37
The Insurer may temporarily suspend benefits for those group insurance applicants or those insured that have been proven to have the ability to pay the premium and the overdue charge through investigation and supervision, but have chosen not to do so. However such restrictions do not apply to portion of the premium payable withheld by or paid to the group insurance applicants, those approved by the Insurer as having to be paid in installments according to the previous article, or the premium payable during the period of time the insured is receiving protection under the Domestic Violence Prevention Act.

The premium during the temporary suspension of benefits should still be collected.

Article 38
Whenever the group insurance applicants or premium withholder owe premium or the overdue charge, but have no property for execution or do not have property to pay off their debts, the persons in charge or the persons dealing with the businesses should be responsible for clearing the debts.

Article 39
Premiums and overdue charges of this Insurance take precedence over general claims.

Chapter 5 Insurance Benefits
Article 40
In case the beneficiaries encounter illness, injury, or maternity, the contracted medical care institutions shall provide medical services, drafting fee schedules, drug dispensing items, and regulations governing fee schedule pursuant to Paragraph 2 of the Medical Benefit Regulations, as well as Paragraphs 1 and 2 of Article 41.

The Competent Authority shall determine the procedure of medical visit, medical visit advice, provision of insurance medical services, and other regulations concerning medical services of the preceding paragraph. If the insured is in a correctional facility, the restrictions on treatment schedule and venue, as well as matters relating to guarding, transferring, and method of providing insurance medical services shall be determined jointly by the Competent Authority and the Ministry of Justice.

Article 41
The Fee Schedule and Reference List for Medical Services shall be established jointly by the Insurer and the relevant agencies, experts, beneficiaries, employers, and contracted medical care institutions, and reported to the Competent Authority for approval.

Drug dispensing and fee schedule should be established jointly by the Insurer and the relevant agencies, experts, beneficiaries, employers, and contracted medical care institutions; drug providers and relevant experts as well as patients, should also be invited to voice their opinions and reported to the Competent Authority for approval.

The drafting of the two-abovementioned standards should be in accordance with the medical needs of the insured as well as the quality of medicine. The meeting should be accurately recorded; self-disclosure of the representatives' interests and other relevant information should be made public. The results of the Insurer's medical technology evaluation should be made public before the drafting process begins.

The joint drafting of the procedures in Paragraphs 1 and 2 as well as the drawing up of the list of representatives, its selection process, term of office, disclosure of interests, and other relevant information should be determined by the Competent Authority.
Article 42
The fee schedule and reference list of medical services described in the preceding paragraph shall follow the principle of "equal payment for same nature of illness" and the relative points shall reflect the cost of each medical service. It should be drafted taking into account volume, cases, quality, individuals, and number of days.

The Insurer must first conduct a medical technology evaluation before drafting the medical service items and fee schedule in the preceding paragraph and consider human health, medical ethics, cost-effectiveness of the treatment, and the finances of the Insurance. The same applies for the drafting of the drug dispensing items and fee schedule.

Medical services and drugs are expensive and pose great danger to inappropriate users, which must be presented to the Insurer for review and approval before use, except in emergency situations.

The review items before use as well as the definition and review of emergency situations, standards, and other relevant fee schedules should be drafted in the medical service items and fee schedule and in the drug dispensing items and fee schedule.

Article 43
The beneficiaries are required to pay 20 percent of the expenses of either ambulatory or emergency care and 5 percent of home nursing care expenses; 30 percent, 40 percent, and 50 percent of the expenses if they visit outpatient departments of district hospitals, regional hospitals, and medical centers respectively directly without referral.

The insured in areas with inadequate medical resources will be exempted from paying self-bearing expenses.

The Competent Authority may, when necessary, sanction the collection of a fixed amount of expenses, which the beneficiaries mentioned in Paragraph 1 shall pay for and promulgate such amount every year; such amount is to be determined in accordance with the average ambulatory care expense of the preceding year and the ratio prescribed in the Paragraph 1.

The implementation of the referral procedure and regulations in Paragraph 1, as well as the conditions for areas with inadequate medical resources in Paragraph 2, shall be regulated by the Competent Authority.

Article 44
To promote preventive medicine, implement the referral system, and to improve the quality of medicine and treatment, the Insurer should draft the family physicians system.

The benefits of the family physicians system should be paid out on a per person basis; annual benefit payment should be based on the patient’s age, gender, illness, and other individual expenses after correction.

The Competent Authority shall determine the implementation regulations and schedule of the family physicians system in Paragraph 1.

Article 45
The Insurer shall fix a maximum amount for special materials as well as the maximum amount charged by contracted medical care institutions as difference. The Insurer should pay the same amount for special materials with the same functional type.

The Insured should choose the special material designated by the Insurer as the maximum benefit when deemed necessary by the doctor from the contracted medical care institution and pay for the difference.
For the special material items, in which the Insured pays the difference, the permit holder should apply to the Insurer, and upon agreement of the Insurer, present jointly with implementation date to the Board for discussion before submission to the Competent Authority for approval.

Article 46
The Insurer should adjust drug prices based on prevailing market conditions; prices for drugs with patents, which have expired for a year, should start being lowered; gradual adjustment to reasonable prices should be done within five years based on prevailing market conditions.

The Competent Authority shall determine the operating procedure for the adjustment in the preceding paragraph as well as the relevant rules.

Article 47
The ratio of hospitalization expenses to be borne by the beneficiaries is as follows:

1. For acute care ward, 10 percent for the first thirty days; 20 percent from the thirty-first to the sixty-sixth day; and 30 percent from the sixty-first day onward;

2. For chronic care ward, 5 percent for the first thirty days; 10 percent from the thirty-first to the ninetieth day; 20 percent from the ninety-first to one hundred and the eightieth day; and 30 percent from the one hundred and eighty-first day onward.

The maximum amount to be borne by the insured for hospitalization in acute care ward for not more than thirty days, or in chronic ward for not more than one hundred and eighty days for the same illness and the maximum amount for the accumulated self-bearing expenses shall be determined by the Competent Authority.

Article 48
In case of the following circumstances, the beneficiaries shall be exempted from payment of the expenses prescribed in Article 43 and the previous article:

1. Major illness and injury;
2. Child delivery;
3. Receiving medical care in mountain regions and outlying islands.

The rules relating to the exemption from the payment of expenses as well as major illnesses and injuries referred to in the preceding paragraph, the procedure for applying for proof of major illness and injury, and other relevant regulations shall be determined by the Competent Authority.

Article 49
In case where the low-income households eligible under the Public Assistance Act make medical visit, the central competent authority in charge of social affairs shall prepare budget to pay for that, according to Articles 43 and 47. However, those who do not abide by referral provisions may not receive subsidies except for those in special situations.

Article 50
The beneficiaries shall pay to the contracted medical care institutions for the self-bearing expenses prescribed in Article 43 and 47.

The Insurer should be notified in cases where the beneficiaries fail to pay the expenses according to the preceding paragraph after being notified and duly demanded by the contracted medical care institutions; the Insurer may suspend benefits to the beneficiaries when necessary and when it has been determined, through investigation and supervision, that the Insured is capable of paying but is unwilling to pay premiums. However, this is not applicable to individuals who are under protection in accordance with the Domestic Violence Prevention Act.

Appendix: The NHI Act
Article 51
Expenses arising from the following service items are not covered in this Insurance:

1. Medical service items on which the expenses shall be borne by the each level of government according to other laws or regulations;

2. Immunization and other medical services on which the expenses shall be borne by the government;

3. Treatment of drug addiction, cosmetic surgery, non-post-traumatic orthodontic treatment, preventative surgery, artificial reproduction, and sex conversion surgery;

4. Over-the-counter drugs and non-prescription drugs which should be used under the guidance of a physician or pharmacist;

5. Services provided by specially designated doctors, specially registered nurses and senior registered nurses;

6. Blood, except for blood transfusion necessary for emergent injury or illness according to the diagnosis by the doctor;

7. Human-subject clinical trials;

8. Hospital day care, except for psychiatric care;

9. Food other than those which are to be tube feeding and balance billing for wards;

10. Transportation, registration fee, and certificate for the patient;

11. Dentures, artificial eyes, spectacles, hearing aids, wheelchairs, canes, and other treatment equipment not required for positive therapy;

12. Other treatments and drugs as stipulated by the Insurer, reviewed by the Board, and promulgated by the Competent Authority.

Article 52
This Insurance shall not apply to a contingency incurred by war, riot, or major plague and act of God, such as severe earthquake, wind storm, flood, fire, that has been identified by the Executive Yuan and provided by all levels of the government with special aids.

Article 53
No insurance benefits shall be paid by the Insurer for any one of the following events:

1. Excessive hospitalization after being notified of discharge from the hospital but refused to do so;

2. Expenses incurred from inappropriate repetitive medical visits or other improper use of medical resources; undergo treatment in medical care institutions not designated by the Insurer. This restriction does not apply in medical emergencies;

3. Treatment and drug which are not medically necessary according to the pre-examination;

4. Violating relevant medical procedures of this Insurance.

Article 54
If medical services provided by the contracted medical care institutions to the beneficiaries were determined by the Insurer to be incompatible with the provisions of this Act, the expenses may not charged to the Insured.

Article 55
The following may apply for reimbursement of self-advanced medical expenses from the Insurer:

1. Those within the Taiwan area who avail of medical visit from non-contracted medical institutions due to emergency or childbirth;
2. Those outside of the Taiwan area who are afflicted with special illness as determined by the Insurer and requiring local medical care due to unforeseen illnesses or emergency childbirth. The reimbursement amount should not be higher than the maximum amount set by the Competent Authority;

3. Those who received medical care services at contracted medical care institutions when their coverage was temporarily suspended but have already paid their premium in full. Those who get medical visits in non-contracted medical care institutions shall fall under the preceding two subparagraphs;

4. Those who receive treatment or who give birth in contracted medical institutions and have to self-advance medical expenses due it is non-attributable to the insured;

5. Those who have covered their own expenses according to Article 47, the annual accumulation of which has already exceeded the maximum amount set by the Competent Authority.

Article 56

The Insured should apply for reimbursement of self-advanced medical expenses according to the preceding article in the following deadlines:

1. Insured persons under subparagraphs 1, 2, or 4 must apply for reimbursement of medical expenses within six months from the day of emergency treatment, or outpatient treatment, or discharge from the hospital. After the deadline, no application will be accepted. Sailors on an ocean-going fishing ship shall apply for reimbursement within six months from the date they come back from the sea.

2. Insured persons under subparagraph 3 should apply for reimbursement within six months from the day relevant expenses are paid in full; this is applicable for cases within the last five years.

3. Insured persons under subparagraph 5 should apply for reimbursement before June 30 of the following year.

The Competent Authority shall determine the documents required of insured persons applying for reimbursement of self-advanced medical expenses, reimbursement standards and procedure, and other relevant matters.

Article 57

The Insured may not make repetitive application or receive duplicated payment in cash of benefits under this Insurance for the same incident.

Article 58

From the date of withdrawal, no benefits shall be payable for the beneficiaries who withdraw from coverage according to Article 13; the Insurer should return all extra premium. If the benefits have already been received, the beneficiaries shall return them to the Insurer.

Article 59

The right of the beneficiaries to receive cash reimbursement for self-advanced medical expenses should not be transferred, offset, seized or object to security interest.
Chapter 6 Payment of Medical Expense

Article 60
The range of the total amount of the medical payment of this Insurance each year shall be proposed by the Competent Authority no later than six months prior to the commencement of the fiscal year and reported to the Executive Yuan for approval after consultation with the Board.

Article 61
The Board shall negotiate and reach the agreement on, no later than 3 months prior to the commencement of each fiscal year, the aggregate amount of the medical payment and the method of allocation, within the range of the total amount of the medical payment approved by the Executive Yuan under the previous article, and report to the Competent Authority for approval. The Competent Authority shall make decision at its own discretion in case the Board does not reach an agreement in time.

The allotment for ambulatory care and hospitalization expenses of the budget for the aggregate payment described in the preceding paragraph may be specified by district.

The allocation ratio and a system of separating accounts for medical and pharmaceutical expenses may be established in regard to the budget for the ambulatory care services provided by physicians, Chinese medicine doctors and dentists, pharmaceutical services and expense of drugs.

After the benefit expense package in Paragraph 1 has been drafted, the Insurer should ask premium payer representatives, insurance medical care provider representatives, and experts to study and promote the global budget payment system.

The agenda for the study process in the preceding paragraph should be announced seven days before and the list of attendees and minutes of the meeting made public within ten days after the meeting.

The scope of district mentioned in Paragraph 2 shall be determined by the Insurer and submitted to the Competent Authority for approval.

Article 62
The contracted medical care institutions shall declare to the Insurer the points of the medical services rendered and expense of drugs, based on the Fee Schedule and Reference List for Medical Services and the Reference List for Drugs.

Contracted medical care institutions should declare the medical expenses in the preceding paragraph within the first day of month following the treatment to six months. However, should there be unavoidable circumstances, another six months after the fact will be provided.

The Insurer shall calculate the value of each point based on the budget allocated according to in the preceding article and the total points of medical service as reviewed by the Insurer. The Insurer shall pay each contracted medical care institution according to the reviewed points.

The drug expenses shall be paid to the contracted medical care institutions after being examined by the Insurer. In case the payment of expense exceeds the preset total of drug expense ratio target, exceeding the targeted amount, the Insurer shall adjust the drug expense payment and payment schedule for the following year. The amount in excess shall be deducted from the budget for the medical benefit payment for the current season and adjust the payment to contracted medical care institutions according to expenditure targets.
Article 63

The Insurer, in order to examine the item, quantity and quality of the medical service of this Insurance provided by the contracted medical care institutions, shall appoint medical and pharmaceutical specialists who have clinical or relevant experiences to conduct the review, which should be based on the approved payment; the review work should be assigned to the relevant professional agency or group.

Review of the medical services in the preceding paragraph shall be done before, during, and after the matter; sampling or case analysis will be the methods used.

The Competent Authority shall establish the procedure and schedule for medical expense application and payment, as well as rules for reviewing medical services.

The Insurer shall be responsible for drafting the contract items of Paragraph 1, the contracted institutions, qualifications of the group, selection and revision of procedure, supervision and relevant pertaining to rights and responsibilities and reporting these matters to the Competent Authority for approval.

Article 64

In case the other contracted medical care institutions fill the prescription, conduct lab tests or diagnostic examinations in accordance with the physician's instruction, and the Insurer, after the examination determines not to pay the benefits due to the physician's improper instruction, such expenses incurred thereof shall be borne by the medical institution where the physician practices by applying for reduction of medical expenses.

Article 65

Paragraph 3 of Article 61, and Paragraph 4 of Article 62 may be implemented in stages, with the respective implementation dates to be set by the Competent Authority. Before the implementation date, the amount of payment for each point in the Fee Schedule and Reference List for Medical Services shall be decided by the Competent Authority.
Chapter 7 Contracted Medical Care Institutions

Article 66
Medical care institutions should apply to the Insurer to become contracted medical care institutions. The Competent Authority shall determine the qualifications, procedure, review standards, disqualification, resolution of violations, and other relevant matters pertaining to contracted medical care institutions.

The medical care institutions of the preceding paragraph are limited to those in Taiwan, Penghu, Kinmen, and Matsu.

Article 67
Provisions of ward in a contracted hospital shall comply with the criteria for establishment of the insurance ward. The criteria for establishment of insurance ward and the ratio of the insurance ward to the aggregate number of hospital wards shall be established by the Competent Authority.

Contracted hospitals should announce the status of their insurance wards daily.

The Insurer should announce the ratio of insurance ward monthly and conduct quarterly checks.

Article 68
With regard to the medical benefit provided by this Insurance, unless provided otherwise by this Act, the contracted medical care institutions shall not make up items to charge the beneficiaries.

Article 69
The contracted medical care institutions shall check the qualification of the insured when they visit, matching it to the information on the health insurance card. The Insurer may refuse to pay medical expenses for those who have not been checked and shall seek reimbursement if the medical expenses have been paid. This is inapplicable to matters not attributable to contracted medical care institutions.

Article 70
Upon occurrence of an incident under coverage to the insured, the contracted medical care institutions shall provide proper medical service based on their specialties and facilities or assist in referral without any unreasonable refusal due to the status of the insured.

Article 71
Contracted medical care institutions should give the Insured a prescription after treatment, which shall be according to the dosage, lab tests, and diagnostic examinations.

The Insured’s drug prescription from ambulatory treatment and major lab test items should be stored in the health insurance IC card.

Article 72
To reduce cases of ineffective treatment and other inappropriate use of insurance medical resources, the Insurer shall draft an annual proposal for controlling inappropriate use of resources; present it to the Board for discussion, and submitting it to the Competent Authority afterwards for approval.

Article 73
Contracted medical care institutions which have received medical insurance payments in excess of a specific amount should present to the Insurer financial reports signed by a CPA or reports from audit institutions on national health insurance business, which the Insurer should make public.

The Insurer shall draft the rules pertaining to the amount, deadline, procedure for providing financial reports, the format, and contents to be presented to the Board for discussion and submitted to the Competent Authority for approval afterwards.
The financial report of Paragraph 1 should at least include the following reports:

1. Asset-liability statement
2. Surplus balance sheet
3. Changes in net report
4. Cash flow report
5. Medical revenue schedule
6. Medical cost schedule

Article 74

The Insurer and the contracted medical care institutions should regularly make public information pertaining to quality of care of the Insurance.

The Insurer shall draft the content scope of the quality of care information, how it is made public, and other rules pertaining to it to be presented to the Board for discussion and submitted to the Competent Authority for approval afterwards.

Article 75

When drug expenses applied for by contracted medical care institutions exceeds the amount designated by the Competent Authority, contracts for all transactions with pharmaceutical firms should be signed to define rights and responsibilities, except if purchase of drugs is for rare diseases or other special cases.

The Competent Authority should meet with the Fair Trade Commission, Executive Yuan to draft the definitive contract format for the written contract in the preceding paragraph and other recorded or unrecorded matters.

Chapter 8 Reserve Fund and Administrative Expenses

Article 76

In order to balance the insurance finances, this Insurance shall set aside a reserve fund from the following sources:

1. Surplus from each fiscal year;
2. Premium overdue charges of this Insurance;
3. Profits generated from the management of the reserve fund.
4. Social health and welfare surcharge on tobacco and alcoholic products imposed by the government.
5. Incomes from sources with statutory grounds other than this Act.

Deficiency in the balance of insurance revenue and expenditure of each fiscal year shall be recovered by the reserve fund first.

Article 77

The funds of this Insurance may be managed in the following ways:

1. To invest in treasury bonds, treasury bills, and corporate bonds;
2. To deposit in government owned banks or financial institutions designated by the Competent Authority;
3. To invest in any other program which is beneficial to this Insurance and as approved by the Competent Authority.

Article 78

In principle, the aggregate amount of the reserve fund shall be equal to the aggregate amount of benefit payments in the most recent one to three months based on actuarial principles.
Chapter 9 Collecting and Gathering of Relevant Information and Documents

Article 79

The Insurer may require relevant agencies to provide the necessary information it needs to carry out the business of the Insurance, which the agencies may not refuse.

The information obtained by the Insurer in accordance with the preceding paragraph should be handled responsibly and prudently. The storage and use of relevant information should be carried out according to the Personal Information Protection Act.

Article 80

The Competent Authority may, to review insurance disputes or for administrative reasons, ask the insured, the group insurance applicants, the premium withholders, and contracted medical care institutions to provide relevant documents, such as account records, receipts, medical history, diagnosis records, or cost of medical expenses, and other documents or relevant information. The beneficiaries, the group insurance applicants, premium withholders, and contracted medical care institutions shall not elude, reject, obstruct, or misrepresent, misreport or misstate.

The Competent Authority shall determine the scope, accessing procedure and rules for interviewing and inquiry pertaining to the relevant information in the preceding paragraph.

Chapter 10 Penal Provisions

Article 81

The person who apply for reimbursements or claims medical expenses through improper conduct, or makes false certification, report, misrepresentation, shall be fined equivalent to two to twenty times the benefits or medical expenses received. If criminal offense is involved, he/she shall also be referred to the court. Any medical expenses so received by contracted medical care institutions may be deductible from the expenses claimed or receivable by it.

If a contracted medical institution behaves in the way mentioned by the preceding paragraph, the Insurer may announce the name of the institution, responsible medical personnel, or the name of the individual and the nature of the violation, depending on the severity of the situation.

Article 82

The person who violates the provision of Article 68 shall return the amount received and shall be fined five times of the expenses received.

Article 83

When contracted medical care institutions violate Article 68 or act as described in Paragraph 1 Article 81, aside from the punishment provided for in Paragraph 1 Article 81, the Insurer must study the severity of the situation and decide whether to suspend the contract indefinitely or within a period of time.

Article 84

If a group insurance applicant fails to carry out subscription to this Insurance pursuant to Article 15 for the insured or their dependents, it shall be punished with an amount equivalent to two to four times of the payable premiums in addition to the unpaid premium.
The preceding paragraph is not applicable if the failure is not attributable to the group insurance applicant.

If a group insurance applicant fails to pay the premiums for the insured and his/her dependents, and the premiums were paid by the insured, in addition to returning the premiums paid, the group insurance applicant shall be punished with an amount equivalent to two to four times of the payable premiums.

Article 85
If the premium withholder does not deduct supplementary premium from the Insured according to Article 31, the Insurer shall impose a deadline for covering the payment as well as a fine that is double the deducted amount. Those who do not pay within the specified deadline will be fined three times the amount.

Article 86
If the contracted hospital fails to attain the criteria and the specified ratio of the insurance ward to the aggregate number of hospital ward as provided in Article 67, it shall be fined no less than ten thousand and no more than fifty thousand New Taiwan Dollars based on the inadequate number of beds, and shall be ordered to improve within a given period of time. The Insurer should make improvements within the specified time; the fine shall be continuously imposed for each violation if not improved within the time given.

Article 87
Contracted medical care institutions violating Paragraph 1 of Article 75 which have not signed contracts or have violated the rule set by the Competent Authority according to Paragraph 2 of Article 75 regarding what and what not to record shall be fined not less than twenty thousand and not more than one hundred thousand New Taiwan Dollars. Improvements should be made by the Insurer within the specified time; the fine shall be continuously imposed for each violation if not improved within the time given.

Article 88
If a beneficiary subscribes to this Insurance in violation of the provision of Article 11, he/she shall be subject to a penalty of no less than three thousand and no more than fifteen thousand New Taiwan Dollars in addition to the payment of premium shortfall.

The payment of the premium shortfall described in the preceding paragraph is limited to those payable within the most recent five years.

Article 89
In any of the following cases, a fine in the amount of two to four times of the payment of different premium shall be imposed in addition to the payment of premium differential:

1. The insured payroll-related amount of the insured in Category 1 declared by the group insurance applicants for the insured is less than the regulated insured payroll-related amount;

2. The insured payroll-related amount of the insured in Categories 2, and 3 declared by the insured are less than the regulated insured payroll-related amount.
Article 90
Persons who violate the provisions of Article 70 or Paragraph 1 of Article 80 shall be subject to a fine of no less than twenty thousand and no more than one hundred thousand New Taiwan Dollars.

Article 91
If a beneficiary who, in violation of the provision of this Act, has not subscribed to this Insurance, he or she shall be subject to a fine of no less than three thousand and no more than fifteen thousand New Taiwan Dollars and shall subscribe to this Insurance retroactively from the date on which the beneficiary is qualified for insurance. The benefits shall be suspended before the fines and premium are fully paid.

Article 92
The fines prescribed in this Act shall be imposed by the Insurer.

Chapter 11 Supplementary Provisions

Article 93
The Insurer may apply for provisional seizure of assets from the court and may be exempted from providing a guarantee to group insurance applicants, insured, or contracted medical care institutions, which owe the Insurance relevant payments, or are hiding or transferring assets or avoiding implementing matters.

Article 94
For those insured that are covered by the occupational injury insurance, the medical expenses incurred from the occupational injury contingency shall be paid by the occupational injury insurance.

The Insurer shall be tasked by the Insurer of the Labor Insurance to provide medical benefits for occupational injury insurance.

The Competent Authority shall determine the scope, payment compensation, and other relevant regulations of package and meets with central labor competent authority for approval.

Article 95
In case the third party is liable for the beneficiary due to tortuous accident covered by this Insurance, the Insurer of this Insurances may, after paying the medical benefits to the beneficiary, exercise the right of subrogation against the tortfeasors specifically addressed by the following subparagraphs:


3. In Significant Traffic Accidents other than Motor Vehicle Ones, the Public Nuisance Accidents, or the Food Poisoning Accidents: the Insurer of the compulsory third party liability insurance, or in case that the third-party tortfeasor is without insurances, the tortfeasor himself or herself.

The Competent Authority shall promulgate regulations governing scope, the method, the procedure, and any other matters related to the exercise of that right with respect to the accidents provided by subparagraph 3 of the preceding paragraph.

Article 96
The revenues and expenditures of this Insurance shall be administered by the Insurer as Operation Fund in the annual fiscal budget.

Article 97
All account records, receipts and revenue and expenditure under this Insurance shall be exempted from taxation.

Article 98
The overdue charge, the temporary suspension of benefits, or the fines provided in Articles 35, 37, Paragraph 2 of Article 50, and Article 91 are not applicable to insured qualified as being in financial difficulty.

Article 99
The Competent Authority may work out a budget to establish a fund for the insured, who have financial difficulty in paying premiums to apply for loans without interest in the amount of the premiums of this insurance and the fees they have to pay.

The monthly repayment may not be higher than twice the personal premium set at the time when the borrowers began applying for the loans, unless the borrowers want to repay it earlier at their own will.

The Competent Authority shall determine the loan application, conditions, loan repayment schedule and methods, as well as other relevant matters of the reserve fund of this Insurance referred to in Paragraph 1.

Article 100
Standards for financial difficulties defined in the two previous articles shall be interpreted by the competent authority in reference to relevant standards for social subsidies.

Article 101
The Insurer should check, on a regular basis, the ability to pay of the insured who have either applied for premium payment postponement or loan clearing pursuant to Paragraphs 1 and 2 of Article 87-4 (prior to the Act’s amendment on January 4, 2011).

Article 102
All accumulated deficits incurred before the amendment of this Act on January 4, 2011, shall be shouldered by the central competent authority through annual incremental amounts in the national budget.

Article 103
The Competent Authority shall prepare the Enforcement Rules of this Act.

Article 104
The Executive Yuan shall decide upon the date of implementation of this Act.
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