Key Terminology

The National Health Insurance Act and the Regulations Governing Contracting and Management of NHI Medical Care Institutions mentioned in this section refer to the provisions announced on January 27, 2010 and September 15, 2010.

1. Enrollment and Underwriting

● Group Insurance Applicants

According to Article 14 of the National Health Insurance Act

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 National Defense shall be designated by the Ministry of National 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 4, the group insurance applicants are as follows:

i. For the insured in item 1, subparagraph 4, paragraph 1, article 8, the group insurance applicants shall be designated by the Ministry of National Defense.

ii. For the insured in item 2, subparagraph 4, paragraph 1, article 8, the group insurance applicants shall be designated by Ministry of the Interior.

(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 domicile; however, the public or private social welfare service institutions may be the group insurance applicants for the insured who lives therein.

● Beneficiaries

According to Article 8 of the National Health Insurance Act

The insured shall be classified into the following six categories:

(1) Category 1

i. Civil servants or full-time and regularly paid personnel in governmental agencies and public/private schools;

ii. Employees of publicly or privately owned enterprises or institutions;

iii. Employees other than the insured stipulated in the preceding two subparagraphs, but are otherwise employed by certain employer(s);

iv. Employers or self-employed business owners;

v. Independently practicing professionals and/or technicians.

(2) Category 2

i. Members of an occupational union who have no particular employers, or who are self-employed;

ii. Seamen serving on foreign vessels who are members of the National Seaman's Union or the Master Mariners Association.

(3) Category 3

i. Members of the Farmers Association or the Irrigation Association, or workers over the age of fifteen who are actually engaged in agricultural activities;

ii. Class A members of the Fishers Association who are either self-employed or have no particular employers, or workers over the age of fifteen who are actually engaged in fishery activities.

(4) Category 4

i. Military servicemen whose compulsory service terms are over two months, or who are summoned to serve in the 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 National Defense; and military families who are receiving pensions due to the death of a decedent;

ii. Men of enlistment age for service in the military who are currently in military-substitute service.

(5) Category 5

Members of a low-income household as defined by Social Support Law.

(6) Category 6

i. Veterans and household representatives of survivors of veterans;

ii. Representatives or heads of household other than the insured or their dependents stipulated in subparagraphs 1 to 5 and the preceding item of this subparagraph.

According to Article 9 of the National Health Insurance Act:

The dependents of the insured in Categories 1 to 3, and 6 are stipulated as follows:

(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 the age of twenty and not employed, or are over the age of twenty but incapable of supporting themselves financially, including those who are in school and not employed.

● Payroll-related premium Base

According to Article 21 of the National Health Insurance Act:

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 insured payroll-related amount in the said Grading Table 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 in the top level of the Grading Table of the insured pay-roll related amount must be fivefold higher than the amount in the bottom level, and the said Grading Table must be revised within one month after 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 to another higher level effective from the following month.

According to Article 22 of the National Health Insurance Act:

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

(1) Employees: payroll;

(2) Employers and self-employed: business income;

(3) Independently practicing professionals and technicians: income from professional practice.

If the insured, as stipulated in Categories 1 and 2, has no stable income, the insured shall select the proper insured payroll-related amount from the Grading Table of the insured payroll-related amount, and the said insured payroll-related amount shall be examined by the Insurer, who may make an adjustment at his/her own discretion if the insured payroll-related amount is found to be inadequate.

According to Article 23 of the National Health Insurance Act:

The insured payroll-related amount applicable to the insured in Category 3 shall be the average amount for those specified under items 2 and 3 of subparagraph 1, and subparagraph 2 of paragraph 1, Article 8; the Insurer may adjust the level of the insured payroll-related amount according to the financial viability of the insured and their dependents.

According to Article 25 of the National Health Insurance Act:

The premium of the insured in Categories 4 and 5 shall be calculated according to the average actuarial premium based on the total number of beneficiaries.

According to Article 26 of the National Health Insurance Act:

The premium of the beneficiaries in Category 6 shall be the average premium of all beneficiaries according to the actuarial results.

The premium of the dependents shall be paid by the insured. Where the number of dependents exceeds 3, the payment shall be calculated on the basis of only three dependents.

● Average Payroll-related Premium Base

The average payroll-related premium base for the insured is calculated as follows:

Total of (amount for different types of premium base × number of insured under each category) / Number of insured

● NHI Premium Contribution Proportions

Beneficiaries under the National Health Insurance program are divided into six categories, and the premium contribution rates to be borne or subsidized by the insured, the group insurance applicant, and the government vary depending on the category of beneficiaries (see table below).

Category of Beneficiaries			Percentage (%)		
			The Insured	Group Insurance Applicants	Government
Category 1	Civil Servants, Voluntary Military Personnel, Government Employees	The Insured and Dependents	30	70	0
	Private School Faculty and Staff	The Insured and Dependents	30	35	35
	Employees with Certain Employer(s) in Public or Private Enterprises or Institutions	The Insured and Dependents	30	60	10
	Employers, Self-employed Business Owners, Independently Practicing Professionals and Technicians	The Insured and Dependents	100	0	0
Category 2	Occupational Union Members Without Specific Employers, Alien Seamen	The Insured and Dependents	60	0	40
Category 3	Farmers, Fishermen, and Members of Irrigation Associations	The Insured and Dependents	30	0	70
Category 4	Conscription Draftees, Military School Students, Bereaved Dependent(s) of Deceased Serviceman, Substitute Civilian Serviceman	The Insured	0	0	100
Category 5	Low-income Households	The Insured	0	0	100
Category 6	Veterans, Household Representatives of Survivors of Veterans	The Insured	0	0	100
		Dependents	30	0	70
	Other District-level Residents	The Insured and Dependents	60	0	40

National Health Insurance charges different levels of premium based on insured payroll-related amount, premium rate, and contribution or subsidy percentage. The formulae are shown below.

(1) Contribution from the insured and dependents:

i. The insured and dependents in Categories 1 to 3:

Insured payroll-related amount × Premium rate × Contribution rate × (1 + Number of dependents)

ii. Veteran's surviving dependents in Item 1 of Category 6:

Average premium × Contribution rate × Number of dependents

iii. District-level residents in Item 2 of Category 6:

Average premium × Contribution rate × (1 + Number of dependents)

(2) Contribution from group insurance applicants:

Insured payroll-related amount × Premium rate × Contribution rate × (1 + Average number of dependents)

(3) Contribution from government subsidies:

i. The beneficiaries in Categories 1 to 3:

Insured payroll-related amount × Premium rate × Contribution rate × (1 + Average number of dependents)

ii. The insured in Categories 4 and 5:

Average Premium × Contribution rate × Actual number of the insured

iii. The beneficiaries in Category 6:

Average Premium × Contribution rate × (1 + Number of dependents)

When the number of dependents exceeds 3, the payment shall be calculated on the basis of only three dependents. The number of dependents in Categories 1 to 3 shall be the average number of the dependents that the insured in Category 1 to 3 actually have. The current average number of dependents is 0.7 people (adjusted in January 2007).

2. Financial Status

● Premium Receivable

This is the amount of premium that is receivable each month (year).

● Premium Collected

This is the premium that is received with receipt each month (year).

● Collection Rate

(Premium Collected / Premium Receivable) × 100

● Statutory Government Subsidies

This indicates premium paid by various levels of government according to Article 27 of the National Health Insurance Act.

● Non-statutory Subsidies (Government subsidies to specific targets)

This indicates the separately-budgeted government subsidies for premium payments which were originally payable by the insured or the group insurance applicants pursuant to the National Health Insurance Act.

● Income from Medical Service Provision

This is the subsidy given from government authority to the NHIA for providing medical services. The medical services provided by the NHIA are, for example: medical fees of preventive care services, co-payments for veterans, household representatives of survivors of veterans; co-payments for low-income citizens; hospital fees for low-income patients; treatment fees for a reportable infectious disease; treatment fees and hospital fees for occupational injury and disease; prevention and checkup of occupational injury and disease.

● Delinquency Charges

Delinquency charges shall be calculated as 0.1% of the amount to be paid for every one day delayed for the insured unit and the insured. However, the maximum delinquency charge is capped at 15%; small delinquency charges under a certain amount, as determined by the competent authority, do not have to be paid.

● Collection Rate of Delinquency Charges by Number

(Number of Delinquency Charges Collected / Number of Delinquency Charges) × 100

● Collection Rate of Delinquency Charges

(Delinquency Charges Collected / Delinquency Charge Receivables) × 100

● Reserve Fund

According to Article 63 of the National Health Insurance Act:

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

(1) Proportion stipulated by the Competent Authority within 5 percent of the total premium revenues of each fiscal year;

(2) Surplus from each fiscal year;

(3) Premium overdue charges;

(4) Profits generated from the management of the reserve fund.

Any deficiency in the balance of insurance revenue and expenditures of each fiscal year shall first be recovered by the reserve fund.

● Added Social Health Insurance Contributions for Alcohol and Tobacco

According to Article 4 of Tobacco Hazards Prevention Act:

The collected surcharges shall be used exclusively for the National Health Insurance reserves, for cancer prevention and control, for upgrading the quality of medical care, for subsidizing in the area where found shortage of medical supplies and the operation of related medical units, for subsidizing to the medical expenses of rare disorder or otherwise, for subsidizing to the Insurance fee of the person who need help due to economic difficulties, for implementing hazard-related preventive measures at both national and provincial levels, for promoting public health and social welfare, for investigating smuggled or inferior tobacco products, for preventing tax evasion of tobacco products, for providing assistance to tobacco farmers and workers of relevant industries.

● Social Welfare Lottery Income

According to Article 6 of Public Welfare Lottery Issue Act:

All lottery net revenues shall be used by government only for the national pension system, the national health insurance program's safety reserve and social welfare expenses.

● Medical Expenditures

Medical benefit payments and costs incurred from types of insurance under the National Health Insurance Act.

● Insurance Cost

Insurance payments (medical expenses), interest fees, all types of lodge payments (delinquent accounts, etc), the loss brought by the trading of bills incurred from the NHI's insurance administration.

3. Contracting and Management of Medical Care Institutions

● Contracted Categories of Medical Care Institutions

In accordance with Article 58 of enforcement rules of the national health insurance act, academic medical centers, metropolitan hospitals and local community hospitals are referred to the following:

(1) Academic medical centers: Hospitals accredited as medical centers by the Competent Authority.

(2) Metropolitan hospitals: Hospitals that are accredited as the Second Type by the Competent Authority or qualified in accordance with the metropolitan hospital evaluations.

(3) Local community hospitals: Hospitals that are accredited as the First Type by the Competent Authority or qualified in accordance with the local community hospital evaluations.

● Insured Beds

Beds that are provided by contracted hospitals to the insured without collecting the fees needed for the balance billing.

● The Proportion of Insured Beds

This is calculated in accordance to Article 32 of Regulations Governing Contracting and Management of NHI Medical Care Institutions.

(Total Number of Insured Beds in Contracted Medical Care Institutions / total number of beds in contracted medical care institutions) × 100

● The Proportion of Insured Acute Beds

((Insured acute beds－ emergency temporary beds－hemodialysis beds－nursery beds) in contracted medical care institutions / (Acute beds－emergency temporary beds－hemodialysis beds－nursery beds) in contracted medical care institutions) × 100

● The Proportion of Insured Chronic Beds

(Insured chronic beds in contracted medical care institutions / Chronic beds in contracted medical care institutions) × 100

● Penalties

In accordance with Article 36 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions, the insurer may deduct ten times of the reported medical expenses by the service institutions based on the average total value of the most recent quarter of their locations should the service institutions be found under any of the following circumstances:

(1) Failure to provide medical services according to prescriptions, medical history or other records.

(2) Provision of medical services without diagnoses from physicians.

(3) Prescriptions or medical expenses reported not recorded in medical history or records.

(4) Failure to produce medical history or records to facilitate the reporting of medical expenses.

(5) Declaration of medical expenses knowing that patients use insurance certificates of others.

(6) Retention of personnel not in compliance with the laws and regulations governing medical personnel, as described in Paragraph 3 of Article 38, to perform the duties that shall be performed by specific medical personnel.

The insurer is entitled to offset the above deductible expenses directly from the amount otherwise payable to the NHI contracted medical care institute.

● Corrections

In accordance with Article 35 of Regulations Governing Contracting and Management of NHI Medical Care Institutions, the insurer may impose one contract-violation point to the service institutions for any of the following circumstances:

(1) Patient transfer not conducted in accordance with medical laws or laws and regulations in relation to the National Health Insurance.

(2) Violation of Articles 10 to 12, Articles 14 to 15, Article 24, Paragraph 2 of Article 31, Article 32 or Article 33.

(3) Failure to audit the medical papers of insurance beneficiaries in accordance with the Regulations Governing the Medical Services Covered under National Health Insurance.

(4) Failure to return the medical expenses paid by insurance beneficiaries at their own expenses, as stipulated by the Regulations.

(5) Failure to charge insurance beneficiaries the fees they shall pay at their own expenses or declare medical expenses, as stipulated by the Regulation.

(6) Improper solicitation of patents for accepting medical services covered by the insurance and such behavior penalized by the health competent authority.

(7) Failure to rectify the situation within the deadline set forth by the Insurer.

● Suspension of Contract

In accordance to Article 37 of Regulations Governing Contracting and Management of NHI Medical Care Institutions, the insurer shall suspend contract for one to three months should the service institutions be found under any of the following circumstances during the term of the contract validity. However, it is possible to suspend specific service items or categories rendered by contracted hospitals for one to three months:

(1) Violation of Article 58 or Article 62 and again after three disciplinary actions by the Insurer.

(2) Violation of Article 35 and subject to the punitive measure of three contract-violation points and the same violation again.

(3) One of the subparagraphs in the preceding article after medical expenses being deducted three times.

(4) Declaration of medical expenses for non-insurance beneficiaries in the name of insurance beneficiaries.

(5) Provision of medications, nutrient supplements or other items not necessary for treatments to insurance beneficiaries, registration of unnecessary medical services and declaration of medical expenses.

(6) Refusal to provide appropriate medical services to insurance beneficiaries and such offense being

significant.

(7) False declaration of medical expenses by forging medical records despite no diagnosis or treatment rendered.

(8) Other unscrupulous behavior or false certifications, reports or statements to declare medical expenses.

● Termination of Contract

In accordance with Article 38 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions, the insurer shall terminate the contract should the service institutions be found under any of the following circumstances. However, the Insurer may simply suspend specific service items or categories rendered by contracted hospitals for one year:

(1) Service institutions or their responsible medical personnel has been suspended pursuant to the preceding Article and the same offence was found within ten (10) years after the completion of such suspension.

(2) Unscrupulous behavior or false certifications, reports or statements to declare medical expenses and such offense being significant.

(3) Violation of medical laws and regulations, and practicing licenses revoked by the competent health authority.

(4) Retention of personnel not qualified as medical personnel to provide medical services to insurance beneficiaries.

(5) Reporting of false dates in order to declare the expenses for medical services rendered to insurance beneficiaries during the period when the contract is suspended; or requesting other service institutions to declare such expenses.

(6) Contract terminated or suspended for a year pursuant to the above subparagraphs 1-5, and aforesaid offenses found within one year of resumed contracting after the previous contract termination or suspension of the contract.

No application for contracting is permitted within one year after the termination of the contract pursuant to the preceding paragraph.

For the retention of personnel not qualified as medical personnel to provide medical services rendered by physicians, as described in Subparagraph 4of Paragraph 1 of this article, it is possible to waive the termination of the contract if such offense has been rectified pursuant to Article 36.

4. Medical Benefits

● Number of Outpatient Cases

The number of outpatient cases after registration in contracted medical institutions, including

emergency cases.

- Number of Inpatient Cases

  For filing of inpatient cases, if the insured has not checked out of the hospital at the end of the current month, the expenses should be filed altogether after the insured has checked out. For chronically hospitalized patients, filing may be done every two months. Monthly filing is also allowed if deemed necessary.

- Medical Points

  Requested Points + Copayment

- Requested Points

  This refers to those being claimed on such year or month.

- Approved Benefit Payments / Points

  The payments /points that are granted in accordance to the fee incurred on such year or month after initial verification.

- Copayment

  Copayment refers to the medical expense borne by the insured when visiting a contracted medical institution for treatment.

- Inpatient Days

  This refers to the days starting from the day that the insured is checked into the hospital, including days occupying emergency beds and chronic, until the day the insured is checked out of the hospital (but the day of checkout is not counted).

- Average Medical Points per Case

  Medical Points / Number of Cases

- Average Medical Points per Day

  Medical Points / Total Days in the Hospital

- Average Length of Stay

  Total Days in the hospital / Number of Cases

- Cash Reimbursement of Medical Expense for Out-of-Plan Services

  In case the beneficiaries, under emergency, need to be treated immediately or to give birth in non-contracted medical care institutions, the group insurance applicants may, with the support of the relevant certification documents, apply to the Insurer for reimbursement of the medical expenses. The reimbursement regulation shall be established by the Competent Authority.

  The application for medical expense reimbursement prescribed in the preceding paragraph shall

be submitted within six months after completion of treatment or baby delivery; otherwise, it will be rejected.

- General Cases

  General cases refer to the cases that are being charged based on the price of prescriptions from office-based clinics. General cases of those staying in the hospital refer to cases that are not charged with a high price, specific, or paid by case.

- Case-payment Cases

  This refers to the application for reimbursement of medical expenses in accordance to the international classification of diseases and the classification for operation (treatment) under Section 7 of the Payment Standard for National Health Insurance and relevant regulations.

- Special Cases

  Special cases executed in medical institutions that provide insurance which require examinations on a case by case basis.

- Pilot Project

  A project that has not been under the payment standard, and shall be planned and promoted by the public health administration and the department of local and global budget payment system.

- Delivery Institutions

  These include contracted pharmacies, clinical laboratories, radiological laboratories, physical therapy laboratories, occupational therapy laboratories, and institutes of pathology.

- Tw-DRGs Cases

  Tw-DRGs Cases refer to those specified under chapter 1, Part IX of NHI Payment Standards for Medical Care.

- Inpatient Hospice Care Cases

  Inpatient hospice care cases refer to those specified under section 8, chapter 1, Part II of NHI Payment Standards for Medical Care.

- Commission cases

  Commission cases refer to entrusted cases which are not covered under National Health Insurance.

- Major Illness/Injury

  This refers to the types of injury and diseases according to Article 2 of Regulations Governing the Exemption of the National Health Insurance Beneficiaries from the Co-Payment.

- Floating Point Value

(Budget for the quarter - approved non-floating points for general services - reimbursement of advanced payments) /Approved floating points for general services.

For dental institutions and institutions practicing western medicine, the global budget for the current quarter included the additional expenses incurred from new areas applicable to the "Separation of Prescription and Dispensing" policy.

- Average Point Value

Budget for the quarter / (Approved non-floating points for general services + Approved floating points for general services + Reimbursement of advanced payments)

For dental institutions and institutions practicing western medicine, the global budget for the current quarter included additional expenses incurred from new areas applicable to the "Separation of Prescription and Dispensing" policy.