Key Terminology

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:

$$\frac{\text{Total of (amount for different types of premium base} \times \text{number of insured under each category)}}{\text{Number of insured}}$$

- 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

$$\frac{\text{Premium Collected}}{\text{Premium Receivable}} \times 100\ \%$$

- 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 Bureau of National Health Insurance, Department of Health for providing medical service. The medical service provided by the Bureau of National Health Insurance are: self-paid medical expenses for veterans, household representatives of survivors of veterans; self-paid medical expenses for low-income citizens, patients with tuberculosis; and self-paid medical expenses for treatments; ward fees and diagnostics fees for patients with open tuberculosis and those patients who live in remote areas with open tuberculosis; fees for staying in a recovery home; 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

$$\frac{\text{Number of Delinquency Charges Collected}}{\text{Number of Delinquency Charges}} \times 100\ \%$$

- Collection Rate of Delinquency Charges

$$\frac{\text{Delinquency Charges Collected}}{\text{Delinquency Charge Receivables}} \times 100\ \%$$

- 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 64 of the National Health Insurance Act:

The government may impose the social health and welfare surcharge on tobacco and alcoholic products and deposit a proportion of the surcharge collected therefrom in the reserve fund.

Notwithstanding the relevant provisions of the Act Governing the Allocation of Government Revenues and Expenditures, the implementation regulations for setting aside a proportion of the social health and welfare surcharge as the reserve fund shall be jointly promulgated by the Competent Authority and the central competent authority in charge of finance.

- Social Welfare Lottery Income

According to Article 65 of the National Health Insurance Act

The government shall set aside a certain proportion of returns from social welfare lottery as the reserve fund.

The implementation regulation for the preceding paragraph shall be jointly established by the Competent Authority and the central competent authority in charge of finance and shall not be subject to the limitations of the relevant provisions of the Government Fiscal Revenues and Expenditures Allocation Law.

- 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.

- Advances on Medical Expenses

This refers to the advances that are used to pay for medical expenses when the insurance income is not enough to pay for medical expenses.

3. Contracting and Management of Medical Care Institutions

- Hospital by Contracted Category.

Academic Medical Centers

This includes the medical center, those centers that are evaluated as outstanding in the "New System Hospital Accreditation Scheme", and those evaluated as excellent in the "New Teaching Hospital Accreditation" (a hospital that is within the maximum number of applicants when applying for the "payment for hospital centers" under the annual accreditation scheme).

Metropolitan Hospitals

These include metropolitan hospitals and those hospitals rated as outstanding, excellent, or qualified in the "New System Hospital Accreditation Scheme" (hospital that is within the maximum number of applicants when applying for the "payment for hospital centers" under the annual accreditation scheme); those hospitals that are rated as excellent and qualified in the "New Psychiatric Hospital Accreditation", and as qualified in both "New Psychiatric Hospital Accreditation" and "New Hospital Accreditation of Psychiatry".

Local Community Hospitals

These include local community hospitals under the accreditation scheme; some of the western hospital projects that are disqualified by the accreditation scheme, and shall be considered as qualified following the example of local community hospital, or hospitals that are considered as outstanding in the "New System Hospital Accreditation Scheme" or rated as qualified in the "New System Hospital Accreditation Scheme" (hospitals that did not apply for "medical center payment" or "local community hospital payment" in the accreditation scheme); and those rated as outstanding and qualified in the "New Hospital Accreditation of Psychiatry".

Physician Clinics and Dental Clinics

These include the western hospitals (non-accreditation based, disqualified), Chinese hospitals (non-accreditation based, disqualified), office-based clinics/others.

Pharmacies

The business operating unit that dispenses and provides medicine in accordance to laws and is the unit is operated by a qualified physician or a pharmacist.

- 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.

$$\frac{\text{total number of insured beds in contracted medical care institutions}}{\text{total number of beds in contracted medical care institutions}} \times 100\ \%$$

- The Proportion of Insured Acute Beds

$$\frac{\text{(Insured acute beds − emergency temporary beds − hemodialysis beds − nursery beds) in contracted medical care institutions}}{\text{(Acute beds − emergency temporary beds − hemodialysis beds − nursery beds) in contracted medical care institutions}} \times 100\ \%$$

- The Proportion of Insured Chronic Beds

$$\frac{\text{Insured chronic beds in contracted medical care institutions}}{\text{Chronic beds in contracted medical care institutions}} \times 100\ \%$$

- Penalties

In accordance with Article 36 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions, if any of the following occurs within the health care institute that provides medical insurance, 10 times the amount of the medical expenses of the insured shall be deducted as penalty:

(1) Medical services were not provided according to prescription or medical record.

(2) Medical services were not provided according to the doctor's diagnosis.

(3) Content of the prescription or medical expenses did not correspond to those of the medical record.

(4) Application for the reimbursement of medical expenses did not include medical record(s).

(5) The NHI contracted medical care institute made a claim for NHI medical benefits against services provided to an individual who used the insurance certificate of a third person, and the medical care institute was clearly aware of this fact.

(6) As described in Article 38, Paragraph 3, the NHI contracted medical care institute allowed/retained individuals who were not qualified medical personnel, as stipulated in the relevant regulations, to provide services which should have been provided by designated medical professionals.

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, if the medical care institute is involved in any of the following matters, the insurer shall add one violation point to the record of the said medical care institution.

(1) The transfer of medical service provision to another without complying with relevant medical regulations and this Act.

(2) The violation of Articles 10 to 12, Articles 14 to 15, Article 24, Article 31.2, Article 32 or Article 33.

(3) The examination to check the medical documents of the insured that did not comply with the regulations under this Act.

(4) The NHI contracted medical care institute failed to reimburse the medical expenses advanced by the beneficiary pursuant to relevant NHI regulations.

(5) The NHI contracted medical care institute failed to collect the co-payment due from the beneficiary or claim for medical expenses pursuant to relevant NHI regulations.

(6) The NHI contracted medical care institute inadequately offered medical services to the patients, which are not included within the scope of NHI benefits, and was subjected to disciplinary action on behalf of the competent healthcare authority.

(7) Corrections required to be implemented upon notification by the insured did not occur within the specified time limit.

- Suspension of Contract

In accordance to Article 37 of Regulations Governing Contracting and Management of NHI Medical Care Institutions, if one of the following occurs during the contracting period within the health care institute that provides medical insurance, the medical service under contract, or the type of treatment or service that is in violation of the Act provided to the insured, shall be suspended from 1 to 3 months:

(1) A second violation of Article 58 and/or 62 after being penalized by the insured on three separate accounts to each of the Article.

(2) A second occurrence of the circumstances described under Article 35 after accruing three demerits for violating the Article.

(3) A second occurrence of the circumstances described in (2) of this paragraph after a third deduction of medical expenses.

(4) The NHI contracted medical care institute made false claims for NHI medical benefits as a result of assuming the name of a NHI beneficiary.

(5) Medication, health products, and/or other articles that do not correspond to the symptoms of the

patient are dispensed and registered in the medical record database with the insured's IC card.

(6) Refusal to provide adequate medical services to the insured, thereby causing a serious and adverse effect with such action.

(7) Falsifying a medical record when there has not been such treatment of an insured to claim medical expenses.

(8) Using inappropriate ways or false evidence, report, or account to claim medical expenses.

● Termination of Contract

In accordance with Article 38 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions, if one of the following occurs within the health care institute that provides medical insurance, the medical service under contract, or the type of treatment or service that is in violation of the Act provided to the insured, shall be suspended for 1 year:

(1) There has been a second occurrence of the circumstances described in the previous paragraph within ten years after the termination of contract of any health care institute that provides medical insurance, or those medical staffs who are responsible for administration.

(2) Using inappropriate ways or false evidence, report, or account to claim for medical expenses.

(3) The NHI contracted medical care institute has violated relevant medical care regulations. The competent healthcare authority has since voided the medical license of the institute.

(4) The medical care institute has allowed/retained individuals, who were not qualified physicians, to provide medical services to a beneficiary which should have been provided by qualified medical professionals.

(5) During the suspension period of the NHI contract, the medical care institute made false claims for NHI benefits by reporting an incorrect date, or made claims through another medical care institute.

(6) The insurer terminated or suspended the NHI contract with the medical care institute for one year based on the aforementioned regulations (from subparagraph 1 to the preceding subparagraph), and the medical care institute thereafter applied for reinstatement of the contract. It was however discovered that, during the aforementioned suspension/termination period, the medical care institute was involved in conduct described in the preceding subparagraph.

If the contract of a medical care institute has been terminated due to reasons specified in the previous paragraph, the institute shall not apply for reinstatement of the contract within one year after the date of termination.

It is not necessary to terminate the contract of the medical care institute, however, if the institute

has already been subjected to disciplinary actions as stipulated in Article 36 of the Regulations for allowing unqualified personnel to provide services which should be provided by medical professionals other than physicians, as described in Paragraph 1, subparagraph 4, above.

4. Medical Benefits

- Outpatient Cases

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

- Inpatient Cases

  The number of impatient cases, in which fees will be declared on separate accounts, and one declaration shall be counted as one application.

- Claims

  The medical benefit claims for RVU that are being claimed on such year or month.

- Approved Benefit Payments

  The payment (RVU) that is granted in accordance to the fee incurred on such year or month after initial verification.

- Copayment

  The annual medical expenses 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 RVU Per Case.

  The points for the application of NHI/ number of cases.

- Average RVU Per Day

  The points for the application of staying in the hospital/total days in the hospital.

- Average Length of Stay.

  Total days in the hospital/the number of applications for staying in the hospital.

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

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 require 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 have 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 a contracted medical institution and have to self-advance medical expenses due to that fact that the said expenditures are 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.

● 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 bureau 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.

● 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.

●Tw-DRGs Cases

Tw-DRGs Cases refer to those specified under chapter 1, Part IX 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 listed under the “Scope of Major Illnesses under National Health Insurance” announced by the Department of Health, Executive Yuan.

● 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.