



National Health Insurance in Taiwan







National Health Insurance in Taiwan 2010

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Preface



Health Insurance for All

Over the past 15 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 increasing 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 an example of a single-payer social insurance that has received widespread 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 resolve 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 remote mountainous areas and outlying islands. The program brings socially disadvantaged residents in those areas with timely 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 has to make sure 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 goes beyond the call of duty to better satisfy the needs of the insured.

This commitment goes in tandem with the Bureau's evolution. When the system was 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 variety of indicators. The number of patients going through 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 in operating 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 recognizes that Taiwan's NHI system can be further improved based on 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 will 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 an accomplishment in which all of Taiwan's people can take pride.

History of Taiwan's Social Insurance Programs



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 Farmer Health Insurance program was implemented on a pilot basis in 1985 and fully implemented in 1989. To ensure that the needs of low income families being met, 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, despite the fact that these two population groups are characterized by high demands for medical care and a lack of financial independence. The desire to protect the health of the entire population and provide health insurance for every citizen on an equal footing steered the government's resolve to implement the NHI program regardless of the obstacles encountered.



Labor Insurance

Launched on May 1, 1950, the program aimed at the workers of government-run enterprises, private company employees, 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, accidental injury, and outpatient and inpatient medical services.

Government Employees' Insurance

Started in January 1958, the programs covered the employees of government agencies and holders of elected public office. 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 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 perfect and 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 Act was enacted and put into effect. 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

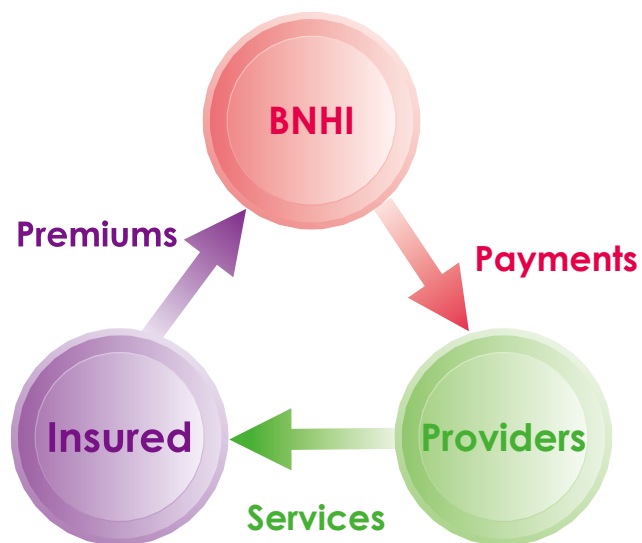
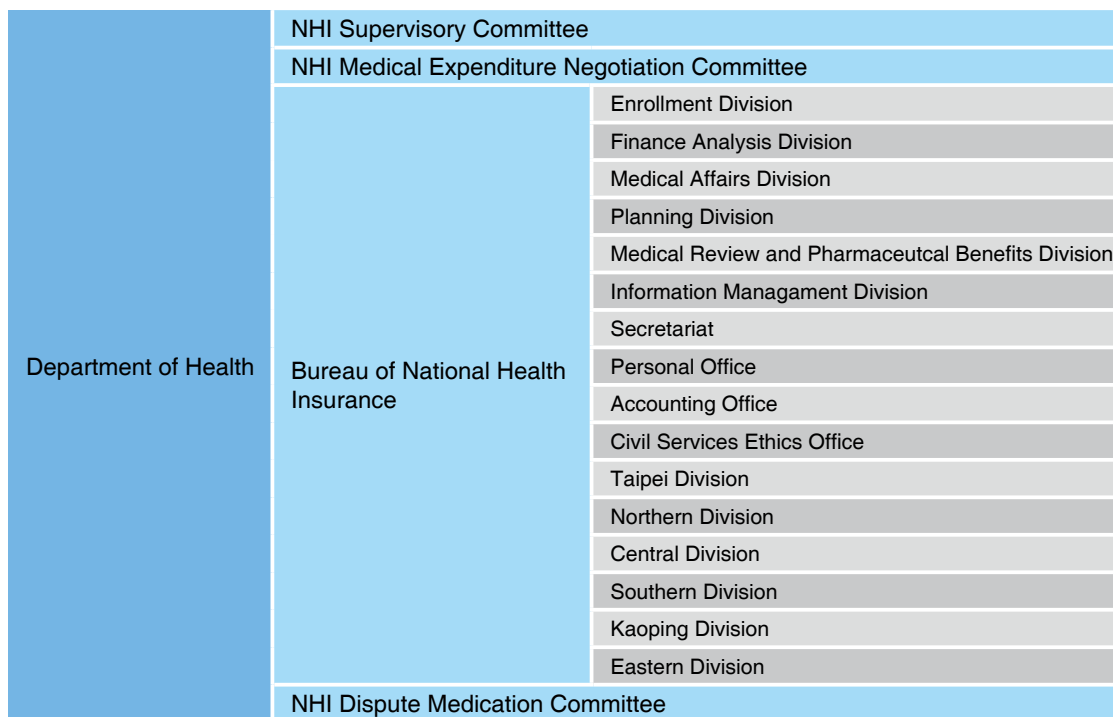


Figure 1 Basic Framework of the NHI System

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, but a copayment as user fees. The medical providers make claims to BNHI for reimbursement of the services they provide.

Figure 2 Organizational Chart of the Bureau of National Health Insurance



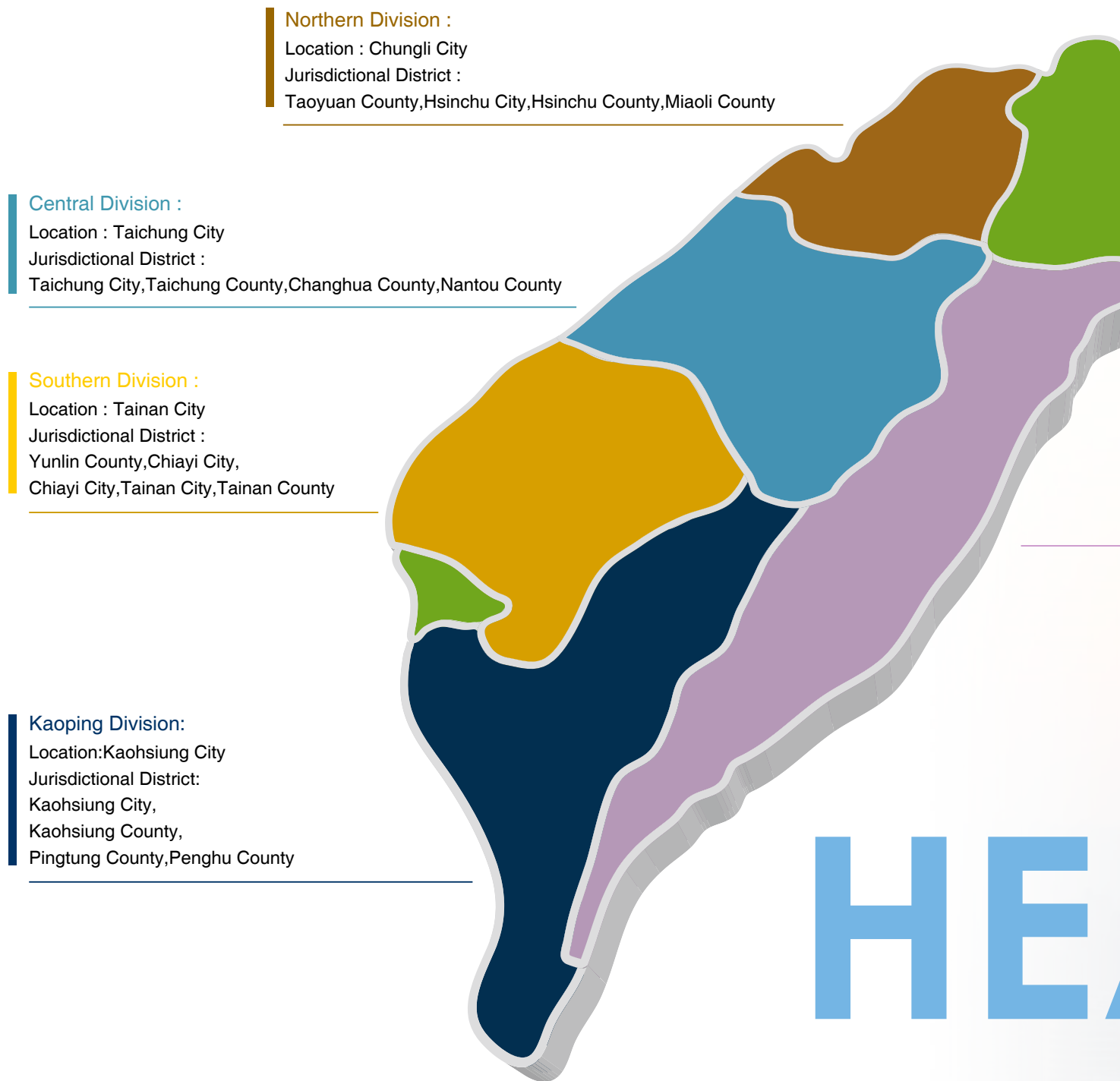
Organizational Team

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 auditing 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 June 2009, the Bureau had 2552 permanent employees and 499 temporary employees, all dedicated to providing the highest level of health care to Taiwan's people.

Figure 3 Service Areas of NHI





Taipei Division:

Location : Taipei City
Jurisdictional District : Taipei City
Taipei County, Keelung City, Yilan County
Lienchiang County, Kinmen County

Eastern Division:

Location : Hualien City
Jurisdictional District :
Hualien County and Taitung County



ALTH 2010

Overview of the NHI Program



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 are covered under the program as soon as their births are registered at a local household registration office.

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 live abroad for more than six months can either maintain their health insurance or have their coverage suspended.

Individuals who reside abroad for more than two years automatically have their household registrations suspended 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-sufficient and responsible for its 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 equaling one month of medical expenditures at least.

The system is primarily funded by the premiums paid collectively by the insured, employers, and 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 legal 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 calculates 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 15 years of existence, the premium rate has only been adjusted twice.

The NHI premium rate was 4.25% from the time the system was launched until September 2002, when it was adjusted to 4.55%. The premium rate was then adjusted to 5.17% in April 2010.

Insured Classification

The insured are divided into six categories based mainly on occupation status, and it determines how their premiums will be calculated and paid (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

Classification of the Insured			Contribution Ratios (%)		
			Insured	Employers	
Category 1	Civil servants, volunteer servicemen, public office holders	Insured and dependents	30	70	0
	Private school teachers	Insured and dependents	30	35	35
	Employees of publicly or privately owned enterprises or institutions	Insured and dependents	30	60	10
	Employers Self-employed	Insured and dependents	100	0	0
Category 2	Occupation union members Foreign crew members	Insured and dependents	60	0	40
Category 3	Members of farmers', fishermen's and irrigation associations	Insured and dependents	30	0	70
Category 4	Military conscripts, alternative servicemen, military school students on scholarships	Insured	0	0	100
Category 5	Low-income household	Household members	0	0	100
Category 6	Veterans and their dependents	Insured	0	0	100
		Dependents	30	0	70
	Other individuals	Insured and dependents	60	0	40

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 Bureau feared that employers might discriminate against individuals with a high number of dependents to avoid paying premiums in their behalf. So it established a system where employers' contributions would be assessed based on an average number of dependents per employee support.

Table - 2 NHI Premium Formulas

Insured Category	Contributor	Formula
Wage Earners	The Insured	Payroll Basis x Premium Rate x Contribution Ratio x (1 + Number of Dependents)
	Insurance Registration Unit or the Government	Payroll Basis x Premium Rate x Contribution Ratio x (1 + Average Number of Dependents)
Non-wage Earning Individuals	The Insured	Average Premium x Contribution Ratio x (1 + Average Number of Dependents)
	The Government	Average Premium x Contribution Ratio x Actual Number of People Insured

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 August 2007, the average monthly premium for individuals in categories 4 and 5 has been NT\$1,317, 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

Brackets	Tiers	Chargeable Payroll (NT\$)	Actual Monthly Payroll (NT\$)	Brackets	Tiers	Chargeable Payroll (NT\$)	Actual Monthly Payroll (NT\$)	
Bracket 1 NT\$600	1	17,280	Under 17, 280	Bracket 7 NT\$3,000	29	60,800	57,801-60,800	
					30	63,800	60,801-63,800	
Bracket 2 NT\$900	31	66,800	63,801-66,800					
	32	69,800	66,801-69,800					
	33	72,800	69,801-72,800					
	34	76,500	72,801-76,500					
	Bracket 8 NT\$3,700	35	80,200		76,501-80,200			
		36	83,900		80,201-83,900			
37		87,600	83,901-87,600					
Bracket 3 NT\$1,200	9	24,000	22,801-24,000		Bracket 9 NT\$4,500	38	92,100	87,601-92,100
	10	25,200	24,001-25,200	39		96,600	92,101-96,600	
	11	26,400	25,201-26,400	40		101,100	96,601-101,100	
	12	27,600	26,401-27,600	41		105,600	101,101-105,600	
	13	28,800	27,601-28,800	42		110,100	105,601-110,100	
Bracket 4 NT\$1,500	14	30,300	28,801-30,300	Bracket 10 NT\$5,400	43	115,500	110,101-115,500	
	15	31,800	30,301-31,800		44	120,900	115,501-120,900	
	16	33,300	31,801-33,300		45	126,300	120,901-126,300	
	17	34,800	33,301-34,800		46	131,700	126,301-131,700	
	18	36,300	34,801-36,300		47	137,100	131,701-137,100	
Bracket 5 NT\$1,900	19	38,200	36,301-38,200		48	142,500	137,101-142,500	
	20	40,100	38,201-40,100		49	147,900	142,501-147,900	
	21	42,000	40,101-42,000		50	150,000	147,901-150,000	
	22	43,900	42,001-43,900		Bracket 11 NT\$6,400	51	156,400	150,001-156,400
	23	45,800	43,901-45,800			52	162,800	156,401-162,800
Bracket 6 NT\$2,400	24	48,200	45,801-48,200	53		169,200	162,801-169,200	
	25	50,600	48,201-50,600	54		175,600	169,201-175,600	
	26	53,000	50,601-53,000	55		182,000	Above 175,601	
	27	55,400	53,001-55,400	*Table took effect from April 1, 2010.				
	28	57,800	55,401-57,800					

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 April 1, 2010, consists of 55 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\$21,000 per month. The insured in category 3 pay premiums based on the pre-set monthly income level of NT\$21,000.

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 18,000 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 expenses 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).

Copayment for Drugs

If medication prescribed to a patient exceeds a certain cost, a 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 4 - Outpatient Care Copayments (NT\$)

Institution Class	Copayments				
Type of Institution	Western Medicine Outpatient Care		Emergency Care	Dental Care	Traditional Chinese Medicine
	With Referral	Direct Visit			
Medical Centers	210	360	450	50	50
Regional Hospitals	140	240	300	50	50
District Hospitals	50	80	150	50	50
Clinics	-	50	150	50	50

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 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\$29,000 for a single hospital stay for a particular condition and NT\$48,000 cumulative for the entire calendar year.

Table 5 - Copayment for Drugs

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

Table 6 - Copayment Rates for Inpatient Care

Ward	Copayment Rates			
	5%	10%	20%	30%
Acute	-	30 days or less	31-60 days	61 days or more
Chronic	30 days or less	31-90 days	91-180 days	181 days or more





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 their dependents, 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.

The outpatient copayment for disabled persons is fixed at NT\$50, while outpatient drug copayments are waived for special cases, holders of refillable prescriptions, 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 August 2009, about 92.47% of the healthcare institutions in Taiwan had signed 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 paid 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





A fee schedule covering more than 4,200 medical service items, 6,400 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 the Diagnosis Related Groups (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 111 diagnosis-related groups into practice since January 2010 and would take 5 years to phase in the complete system.

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.

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 professionalism needed to review them pose considerable 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, patient conditions (such as age, gender, and indications), and etc. It also helps to conduct profile analysis to monitor service utilization abnormality among hospitals. Those outliers will be picked up to undergo underlined peer review.

The review process includes 2 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 tries to develop 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 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 serve as a device of grievance before the case makes its way to the judicial process.



Current Status of NHI



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 equal 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.

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

	Category 1	Category 2	Category 3	Category 4	Category 5	Category 6	Total
No. of Insured	11,797,103	3,998,617	2,973,133	146,011	238,919	3,774,407	22,928,190
% of Total Insured	51.50%	17.40%	13%	0.60%	1%	16.50%	100.00%

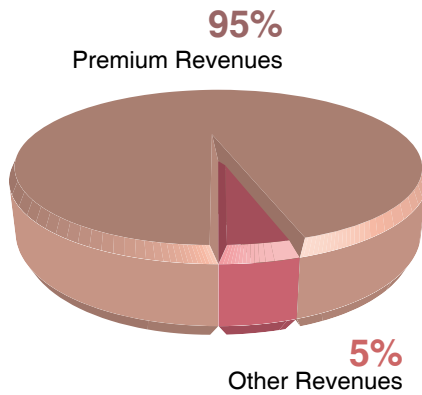


Figure 5
Ratios of Premium Revenue Relative to Total Revenue

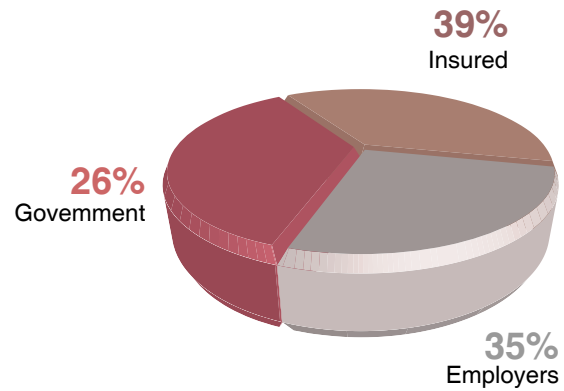


Figure 6
Distribution of Premium Revenues by Source

As of June, 2009, there are 22,928,190 people enrolled in the NHI program, and among the six insured categories, insured in the first category were most numerous at over 11 million persons, accounting for over half of enrollees (Table 7).

Access to Health Care

As of August 2009, 18,936 hospitals and health care providers, or 92.47% of all health care facilities in the country, were contracted by the NHI system. Another 4,370 pharmacies, 483 home nursing care institutions, 153 psychiatric community rehabilitation centers, 15 midwife clinics, 201 medical laboratories, 17 physical therapy clinics, 8 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

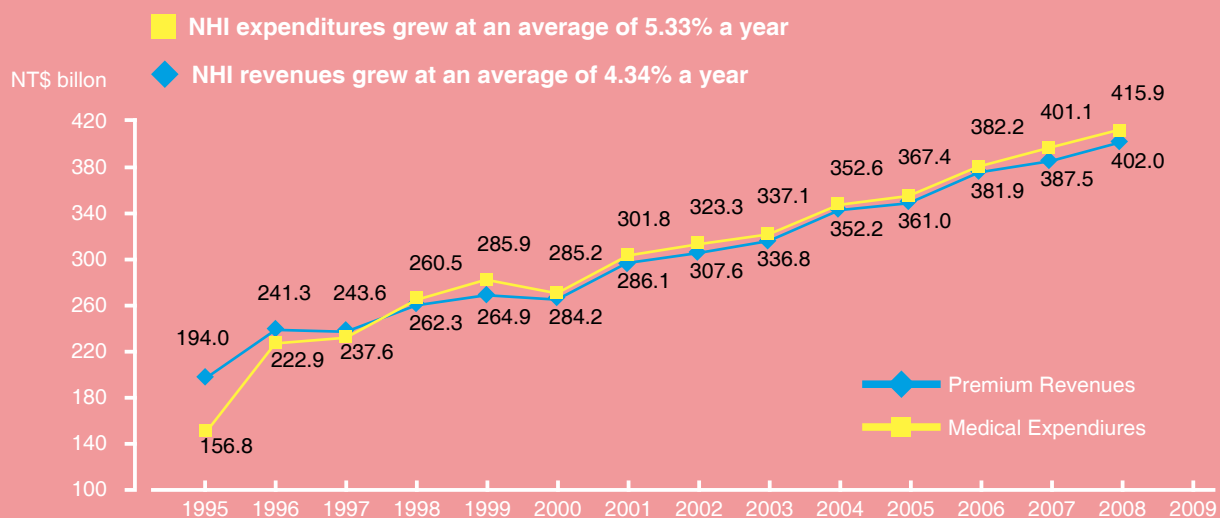
In 2008, the NHI system totaled revenues of NT\$402 billion, with 95% coming from premiums. The remaining 5% came from the health surcharge on cigarettes, contributions from public welfare lotteries, and investment income (Figure 5). Of the premiums, 39% were paid by the insured, 35% by insurance registration organizations (employers), and 26% by government agencies (Figure 6)

On the expenditure side, reimbursement claims for medical services in 2008 totaled NT\$415 billion. Two-thirds (66.75%) of the total submitted was for ambulatory services while the balance was for inpatient care. Medical centers were responsible for just over two-fifths of all outpatient (41.85%) and inpatient (43.08%) claims, followed by regional hospitals (36.92% of outpatient claims and 37.70% of inpatient claims) and district hospitals (21.24% and 19.22%)

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 strengthening of 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 as they did in the early part of the 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 Expenditures Since 1995



However, given the fact that the economy has yet to recuperate 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 the budget comes from the Department of Health. Being a single payer in the healthcare market, the BNHI has successfully lowered 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 only 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.





Easing Financial Burdens of Those with Catastrophic Illnesses

The Department of Health defines what constitutes a "catastrophic illness". 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 August 2009, more than 77 thousand people, or about 3.3% of all those insured under the NHI program, had valid catastrophic illness certificates. The treatment they received in 2008 cost NT\$130.3 billion, or 26.2%, 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 in care, 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 mobile health care. 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 2008, the IDS program offered an average of 1,793 specialty outpatient sessions per month at a cost of NT\$459 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\$3.431 billion.

The IDS program had a 90% satisfaction rating as of 2008, with 100% satisfaction in the mountainous Wulai District of Taipei County, and 99% satisfaction in Nantou County's Renai Township and in Pingtung County's Majia and Sandimen townships.

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 2008, 4,323 services, 7,328 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 2008 are seen in Table 8.

Table 8 - Annual Growth Rates of Global Budgets by Sector

Sector	2003	2004	2005	2006	2007	2008	2009
Total	3.90%	3.81%	3.61%	4.54%	4.50%	4.47%	3.46%
Dental	2.48%	2.64%	2.90%	2.93%	2.61%	2.65%	2.57%
Chinese Medicine	2.07%	2.41%	2.51%	2.78%	2.48%	2.51%	2.49%
Clinics	2.90%	2.70%	3.23%	4.68%	4.18%	4.13%	3.35%
Hospitals	4.01%	4.10%	3.53%	4.90%	4.91%	4.90%	4.46%

Notes:

1. Figures covering from 2003 to 2009.

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 are 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 and asthma 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

Disease	2005	2006	2007	2008
Asthma	32.50%	34.78%	35.17%	31.29%
Diabetes	23.52%	23.16%	24.67%	26.34%
Tuberculosis	68.78%	78.99%	91.81%	Included in the fee-schedule
Breast Cancer	12.09%	12.98%	13.60%	14.46%
Hypertension	N/A	9.31%	6.54%	3.93%

The initial results of these plans have been positive. The one-year survival rate of breast cancer patients has improved and the overall satisfaction rate with the program has surpassed 90%. The number of tuberculosis patients completing their courses of treatment has risen considerably, while diabetes patients in the program have seen noticeable improvement in key indicators, such as HbA1C and GLU-AC (fasting blood glucose).

Asthma patients participating in the plan have experienced a gradual decline in their emergency room visits and frequency of hospitalization, and their overall satisfaction level with the care they are receiving has soared. Finally, hypertension patients have seen clear improvement in their blood pressure levels.

Family Doctors and Community Pharmacies

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 2009, there were 318 community health care groups in existence, with 1,795 clinics, or 19.06% of the country's total, and 2,042 doctors, or 15.92% 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 thoroscopies 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%.

Balance Billing for Expensive Medical Devices

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

Item	Date of Coverage Began
Drug-eluting Stents	Dec. 1, 2006
Artificial Ceramic Hip Joints	Jan. 1, 2007
Artificial Intraocular Lenses	Oct. 1, 2007
Metal-on-metal Artificial Hip Joints	May. 1, 2008

Drug Prices Adjustment

The BNHI has followed legally mandated drug price adjustment guidelines to adjust drug prices and narrow the gap between the actual transaction prices and the NHI listed prices. It has gradually closed the price gap on drugs with similar compositions, dosages of active ingredients, specifications, and forms 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 incompleteness 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 reduce 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, have their contracts with the Bureau suspended for one to three months, or have their contracts terminated, depending on the severity of the offense. 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 of thousands of patients. By the end of December 2008, the average number of doctor visits for the 4,845 patients under counseling who sought treatment 150 times or more in 2007 fell by 20%. The 6,184 patients who sought outpatient care more than 50 times per quarter from the fourth quarter of 2006 to the third quarter of 2007 made on average 20% to 40% fewer doctor visits after receiving counseling.

Finally, the 15,128 patients whose IC card records showed they were making more than 20 outpatient visits a month from January to December 2008 made 40% to 60% fewer visits after receiving counseling.

Disclosure of Quality Information

The BNHI is committed to making health-related information more open 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 2009, 73 quality indicators were posted on the Internet and had received 2,915,206 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 two-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 if the card holder is suffering from a severe condition and the start and expiration dates of the patient's 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 behave 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 of processes that were once handled manually. 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 claims (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.

It is hoped that in the future, software will be available 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. This operating platform can also be accessed by other associations authenticated by the government (such as commercial federations, government agencies, medical groups, organizations and associations, and registered individuals) and is equipped with the following functions:

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.



International Perspectives



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 to gain 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 as % of GDP, 2007

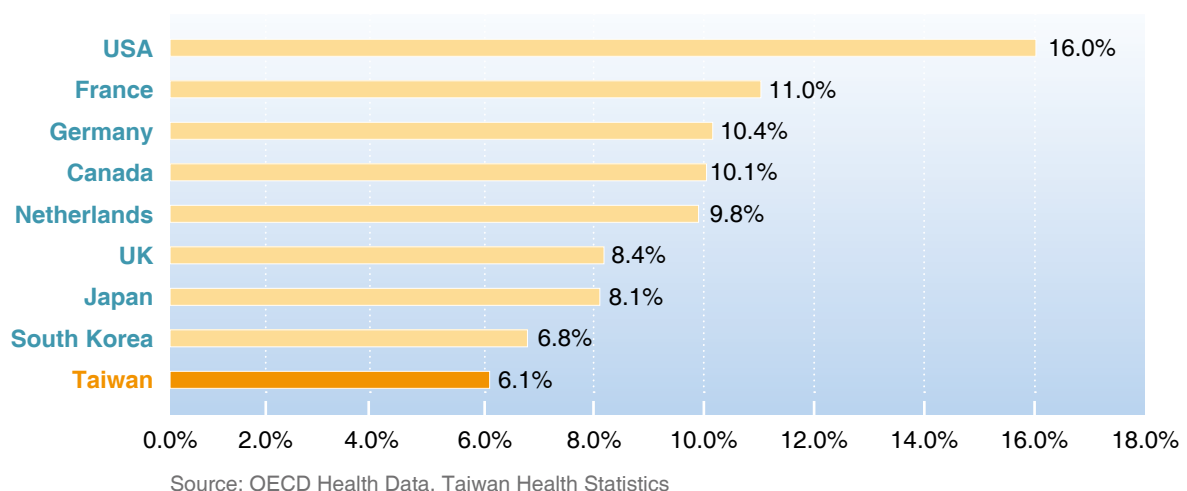


Figure 9 - Per Capita Medical Spending (in USD) in Selected Countries, 2006

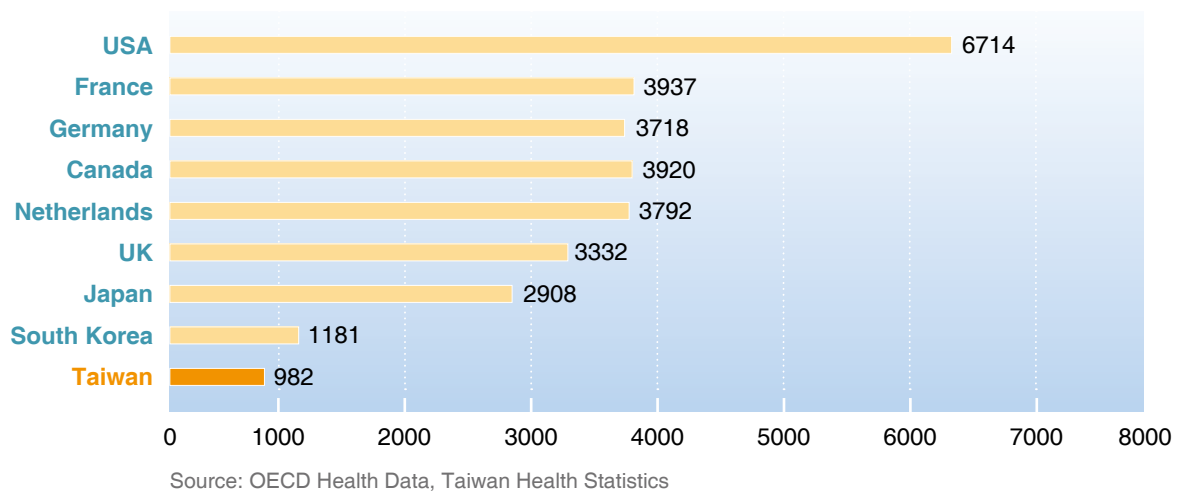


Figure 10 - Growth Rates of Medical Expenditures in Selected Countries from 1997 to 2006

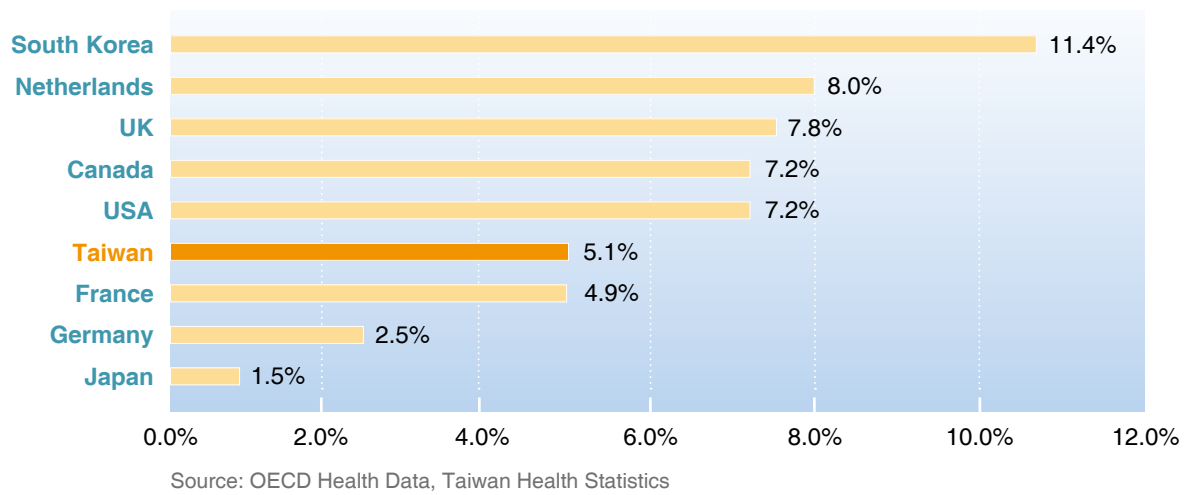


Figure 11 - Growth Rates of Pharmaceutical Expenditures in Selected Countries from 1997 to 2006

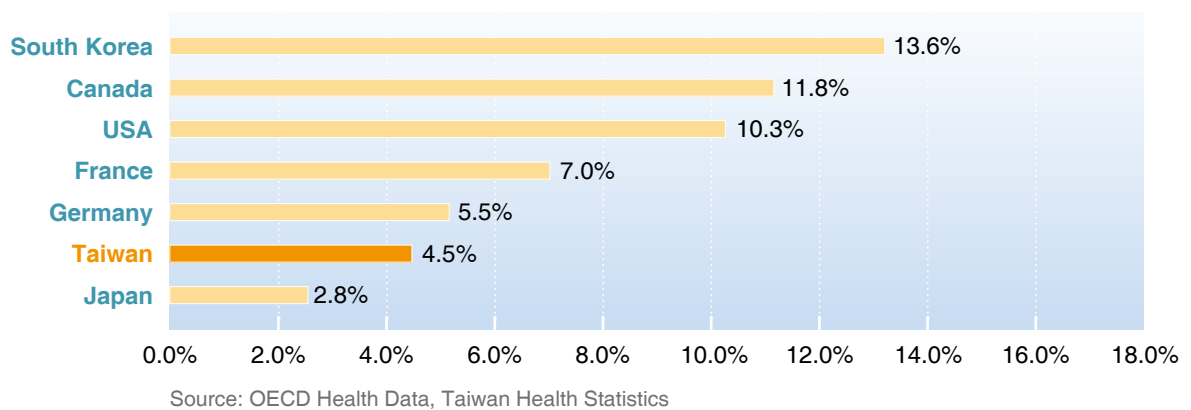


Figure 12 - Physician Visits per Person per year, 2007

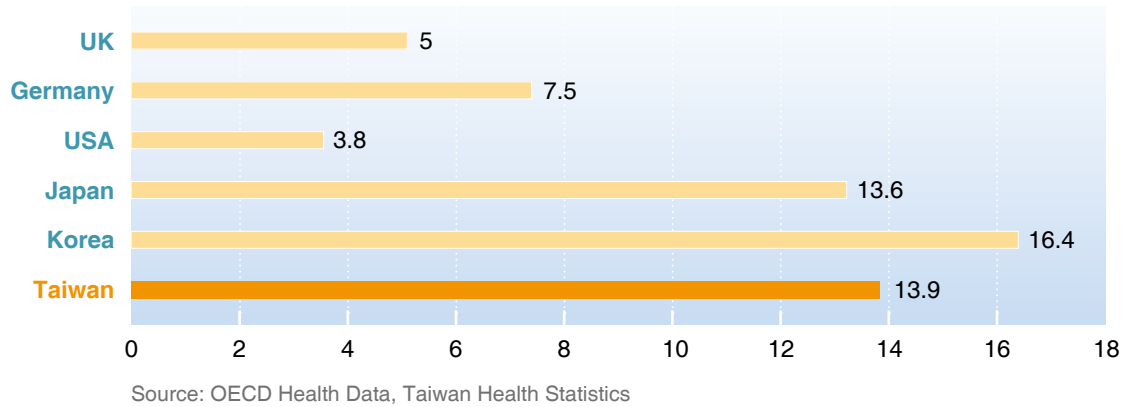


Figure 13 - Average Length of Stay, 2007

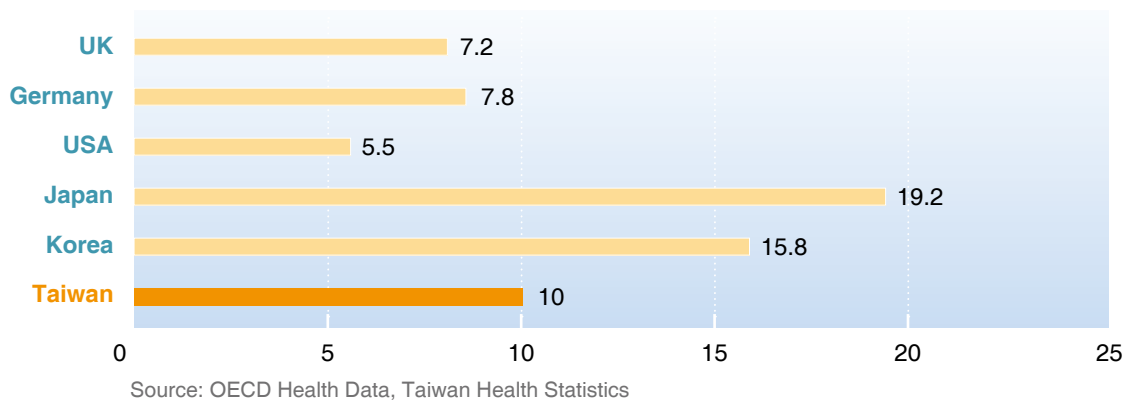


Figure 14 - Acute Care Hospital Beds per 1000 People, 2007

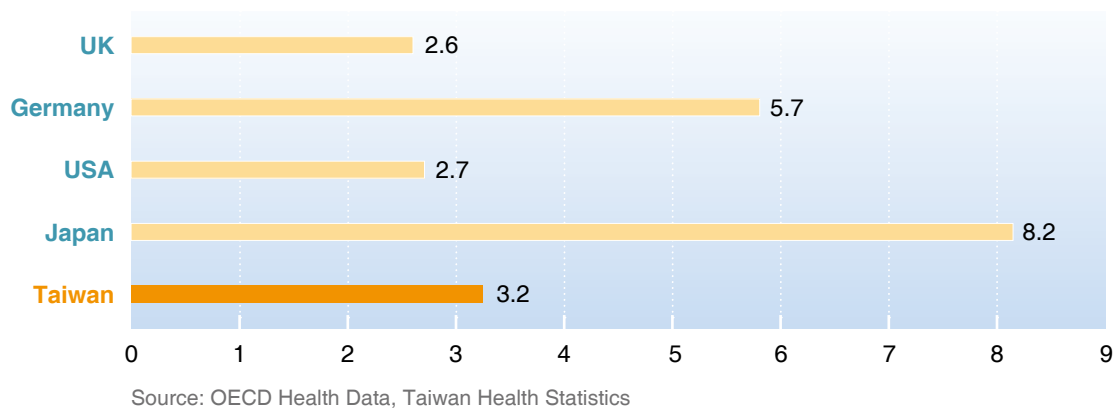


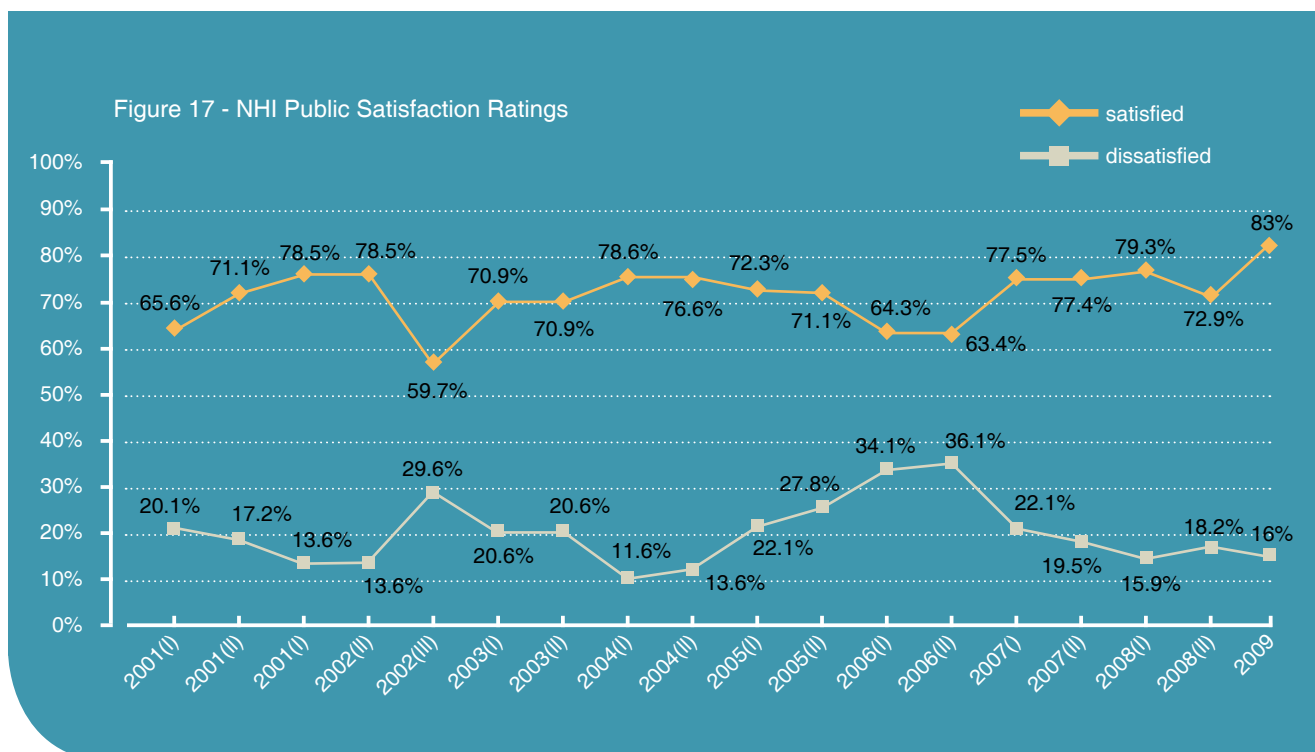
Table 11 - Average Life Expectancy and Infant Mortality Rate, 2007

	Life Expectancy		Infant Mortality Rate (Per 1,000 Live Births)
	Female	Male	
Taiwan	81.7	75.5	4.7
Korea	82.7	76.1	4.1
Japan	86	79.2	2.6
USA	80.7	75.2	6.7
Germany	82.4	77.2	3.8
UK	81.1	77.1	4.8

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 16).



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. To help those who might otherwise be unable to afford the extensive or sophisticated care patients with serious conditions require, the system covers them if they hold a certificate of low-income status obtained from their borough office or health care institution. The system provides them with relief loans and installment plans to ease their financial burden.

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. Among them: 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

As proclaimed by President Ma Ying-jeou, the current premium adjustment plan is only a transitional measure, and that the government will need to continue with the development of the "Second Generation National Health Insurance System", in which, the premium based will be expanded from individual's payroll to a family's total income (including investment gains). The Department of Health will be working actively to bring about the necessary revisions to the laws relating to the National Health Insurance financing system (i.e. to bring about the establishment of the "Second Generation National Health Insurance System"), and will be asking the legislature to give priority to considering the relevant revisions to the law. It is anticipated that the passage of a revised National Health Insurance law can be completed

within two years, thereby helping to 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.

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 many 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 NHI Act



Promulgated on August 9, 1994.

1st Amendment and Promulgated Articles 11-1, 69-1 and 87 on October 3, 1994.

2nd Amendment and Promulgation of Articles 8 to 12, 14, 19, 24, 26, 30, 32, 36, 69, 88 and the Addition of Articles 87-1 to 87-3 on July 15, 1999.

3rd Amendment and Promulgation of Articles 8, 9, 11, 13, 14, 18, 19, 21, 22, 24, 25, and 27-29 on January 30, 2001.

4th Amendment and Promulgation of Articles 21, 27, 29, 32, 55, 87-1, 87-2, and the Addition of Article 22-1 on July 17, 2002.

5th Amendment and Promulgation of Articles 30, 87-1-87-3, and the Addition of Articles 87-4 and 87-5 on June 18, 2003.

6th Amendment and Promulgation of Articles 64 and 82 on May 18, 2005.

CHAPTER ONE

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. Matters not provided for herein shall be governed by other relevant laws.

Article 2

During the insured term, in case of illness, injury or maternity occurred to the beneficiary, benefits shall be provided under the provisions of this Act.

Article 3

The Competent Authority of this Insurance shall be the central competent authority in charge of health.

Article 4

There shall be a Supervisory Board of the National Health Insurance established to supervise the operations of this Insurance and to provide studies and consultation on insurance policy and regulations.

The said Supervisory Board shall consist of specialists and representatives from relevant authorities, the insured, the employers, and the contracted medical care institutions. The organizational rules of the Supervisory Board shall be established by the Competent Authority and submitted to the Executive Yuan for approval before promulgation.

Article 5

There shall be a Disputes Settlement Board (hereinafter the "Board") established under the National Health Insurance to settle disputes arising from cases approved by the Insurer, and raised by the insured, the group insurance applicants or the contracted medical care institutions.

The said Board shall consist of representatives from the Competent Authority and legal, medical and insurance experts. The organizational rules of the Board and the rules for processing disputes shall be made by the Competent Authority and submitted to the Executive Yuan for approval before promulgation.

The insured and the group insurance applicants may file administrative appeal and administrative lawsuit if they disagree with the Board's decision over the disputes in question.

CHAPTER TWO

The Insurer, the Beneficiary and the Group Insurance Applicant

Article 6

The Insurer of this Insurance shall be the Bureau of National Health Insurance established by the Competent Authority to administer the insurance business.

The organization of the Bureau of National Health Insurance shall be prescribed by law.

Article 7

The beneficiary of this Insurance includes the insured and his/her dependents.

Article 8

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 prescribed in the preceding two subparagraphs but are otherwise employed by particular employers;

IV. Employers or self-employed owners of business;

V. Independently practicing professionals and 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 Seamen's Union or the Master Mariners' Association.

3. Category 3

I. Members of the Farmers Association or the Irrigation Association, or workers aged over 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 aged over 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 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 .

II. Men at the age for enlisting in the military, who are currently in military-substitute service.

5. Category 5

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

6. Category 6

- I. Veterans, household representatives of survivors of veterans;
- II. 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 9

The dependents of the insured in Categories 1 to 3, and 6 are prescribed 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 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.

Article 10

Any national of 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 or having established a registered domicile for at least four consecutive months in the Taiwan area prior to subscription of this Insurance;

2. Having established a registered domicile in the Taiwan area at the time of becoming a subscriber to this Insurance and qualified as the insured under items (1) to (3), subparagraph 1, paragraph 1 of Article 8;

3. Newborns having had domicile registration at the time of subscription to this Insurance in the Taiwan area, and qualified under Article 9 as the dependents of the insured.

Any person who has not met the requirements in the preceding paragraph and has an alien resident certificate in the Taiwan area and qualified as the insured under Article 8 or those qualified under Article 9 as the dependents of the insured, upon fulfilling a four-month minimum residency requirement, may subscribe and become covered by this Insurance. Any person qualified as the insured under items (1) to (3), subparagraph 1, paragraph 1 of Article 8 shall not be subject to the four month requirement.

Article 11

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 are confined in the detention centers or in prisons because of criminal punishment, rehabilitative disciplines, or reformatory education, unless their terms are less than two months. Those who are subject to a protective restriction order, however, are still covered by this Insurance;
- 2. Those who have been missing for six months or more;
- 3. Those who have lost the qualifications as prescribed in the preceding Article.

Article 11-1

Except for the circumstances prescribed in Article 11, all the beneficiaries qualified under Article 10 shall subscribe to this Insurance.

Article 12

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 or Category 6.

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

Article 13

The dependents of the insured delineated in article 9 shall subscribe to or withdraw from this Insurance together with the insured.

Article 14

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 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 Defense.
 - II. For the insured in item 2, subparagraph 4, paragraph 1, article 8, the group insurance

applicants shall be designated by the Ministry of 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; 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 8, 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, provided that the premium shall be calculated separately according to the provision of Article 26.

The group insurance applicants prescribed in subparagraph 4, paragraph 1 of this Article shall set up special units or agents to administer relevant matters of this Insurance.

For any one who is covered under Category 6 and undergoing vocational training or exam-taking training at a government-registered institution, such training institution or agency shall be the group insurance applicant.

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

Article 15

The commencement and termination of the insurance shall take effect from the date of occurrence of such conditions or causes specified in Articles 10 and 11.

Article 16

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 for withdrawal.

Article 17

The beneficiaries and the group insurance applicants, when completing insuring formalities, shall provide necessary information or documentation as required and shall not elude, reject, obstruct, or misrepresent, misreport or misstate when interviewed or inquired by the Competent Authority or the Insurer.

CHAPTER THREE

Insurance Finance

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.

Article 19

The premium rate applicable to the insured and their dependents prescribed in the preceding Article shall be set at a maximum of 6 percent. For the first year, the premium payable shall be calculated at the rate of 4.25 percent. From the second year, the premium rate shall be reassessed according to Article 20. If adjustment is necessary, the Competent Authority shall report to the Executive Yuan for approval.

Any deficit incurred during the first two years after the commencement of this Insurance shall be subsidized by the central government.

The premium payable by the dependents articulated in the preceding article shall be paid by the insured. When the number of the dependents

exceeds three, the premium shall be calculated on the basis of only three dependents.

Article 20

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

The premium rate in the preceding paragraph shall be reviewed by the actuary group consisting of 15 to 21 members, who are actuaries, insurance finance specialists, economists and impartial persons designated by the Competent Authority.

Upon occurrence of any of the following events after the actuarial process, the Competent Authority shall readjust the premium rate and report to the Executive Yuan for approval:

- 1.The actuarial mean value of the premium rates for the first coming five years falls beyond the range of plus or minus 5 percent of the premium rate of the current year;
- 2.The reserve fund of this Insurance drops to its minimum required level;
- 3.Any addition to or reduction in benefit items, contents or payment schedules that affects the finance of this Insurance.

Article 21

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 pay-roll 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 insured payroll-related amount to advance another highest level starting from the following month.

Article 22

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. 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 22-1

In case that the insured prescribed in paragraph one of the preceding Article are qualified as the insured under either the public official insurance or the servicemen insurance, their insured payroll-related amounts are calculated as the following: the insured's total amounts of salaries multiply by the ratio of the most recent yearly average insured payroll-related amount of the insured

indicated under items 2 and 3 of subparagraph 1, paragraph 1 of Article 8 and the average regular salaries from various industries announced by the Directorate General of Budget Accounting and Statistics, Executive Yuan.

Article 23

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 8; 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 24

In case that the income of the insured in Categories 1 and 2 as prescribed in Article 22 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. In situations where the insured subscribes to other social insurance schemes, and the insured payroll-related amount shall be adjusted in accordance with the provision in paragraph 5 of Article 22, the group insurance applicant shall, at the same time, notify the insurer of the adjusted insured payroll-related amount. The adjustment of the insured payroll-related amount becomes effective on the first day of the following month after notification.

Article 25

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

Article 26

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. When the number of the dependents exceeds 3, the payment shall be calculated on the basis of only three dependents.

Article 27

This Insurance contribution rates shall be calculated according to the following provisions:

1. For the insured in Category 1:

I. The insured and their dependents referred to in term 1, subparagraph 1, paragraph 1 of Article 8 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 and 35 percent of them subsidized by the executive agencies of education either in the central or in the municipal government.

II. The insured and their dependents referred to in items 2 and 3 of subparagraph 1, paragraph 1 of Article 8 pay 30 percent of the premiums, and the group insurance applicants pay 60 percent of them. For the other 10 percent of premium, it is subsidized by the central government if they register in the provincial jurisdiction, or 5 percent subsidized by the central government and another 5 percent subsidized by the municipal government if they register in the municipal jurisdictions.

III. The insured and their dependents referred to in items 4 and 5 of subparagraph 1, paragraph 1 of Article 8, 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 either by the central government if they register in the provincial jurisdiction or by the municipal governments if they register in the municipal jurisdictions.

3. The insured and their dependents in Category 3 pay 30 percent of the premiums, with the other 70 percent splitted into either (1) 60 percent by the central government and 10 percent by the county's governments if they register in the provincial jurisdiction, or (2) 40 percent by the central government and 30 percent by the municipal government if they register in the municipal jurisdictions.

4. For the insured in Category 4:

I. For the insured in item 1, subparagraph 4, paragraph 1 of Article 8, the institutions they belong shall subsidize their premiums in full.

II. For the insured in item 2, subparagraph 4, paragraph 1, article 8, the Ministry of Interior shall subsidize the premium in full.

5. For the insured in Category 5, the central competent authority in charge of social welfare shall subsidize 35 percent of their premiums with the county (or city) governments subsidizing the other 65 percent when they register in the provincial jurisdiction; while the municipal governments shall subsidize premiums in full when they register in the municipal jurisdictions.

6. The premium payable by the insured referred to in item 1, subparagraph 6, paragraph 1 of Article 8 shall be subsidized by the Veterans Affairs Commission, Executive Yuan. Whereas 30 percent of the premium of the insured dependents shall be paid by themselves 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 8, shall pay 60 percent of the premium and the central government shall subsidize 40 percent.

Article 28

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

Article 29

The premium of this Insurance shall be paid monthly according to the following provisions:

1. The premium to be contributed by the insured in Categories 1 and 4 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 various levels of subsidizing governments to the Insurer no later than the fifth day of the current month.
4. For the insured in Categories 2 to 4 and 6, the premiums shall be partly subsidized by the various levels of governments, Ministry of Defense, or the Veterans Affairs Commission, Executive Yuan, 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 this Insurance for the month when the insured subscribes to coverage shall be fully paid; and that for the month when the insured withdraw from coverage shall be exempted.

If the administrative government agencies delineated in the preceding paragraph do not pay the premium subsidy required by this Act, the Insurer may report it to the competent authority, which may in turn ask the supervisory agencies of the said administrative government agencies to deduct [the amount] from the subsidy allocated to them so as to pay their deferred premium subsidies.

Article 30

A grace period of fifteen days shall be allowed in case that the group insurance applicants or the insured do not pay the premium during the period provided in the preceding Article. If the end of the grace period does not make the payment, 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. However, the amount of overdue charge shall not exceed 15 percent of the amount of the payment due. However, overdue charges of small amounts that are less than an amount to be fixed by the Competent Authority may be waived.

If the premium and the overdue charge referred to in the preceding paragraph payable by the group insurance applicant 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.

Those group insurance applicants or those insured who are unable to pay the premium and the overdue charge provided in the preceding two

paragraphs may apply for payment by installments to the Insurer. The regulations concerning the application conditions, the examining procedure, periods for the payment by installments, and any other regulations to be abided by, will be drafted by the Insurer and be submitted to the Competent Authority for approval.

The Insurer may temporarily suspend benefits and decline issuing the insurance card before the premium and overdue charge are paid in full by the group insurance applicants or the insured, unless the portion of the premium payable by the insured has been withheld by or paid to the group insurance applicants, or has been arranged to pay by installments under the preceding paragraph.

The governments of various levels that do not pay the premium subsidies under paragraph one of the preceding Article are entitled to a grace period of fifteen days. After the grace period, the governments have to pay interests for the amount due. The interest referred to here is calculated daily according to the post office one-year deposit interest rates from the following day of the end of the grace period through the day prior to their payments. The Insurer may refer this case to the court for compulsory execution under the law.

Whenever the group insurance applicants owe the premium or the overdue charge, but have no property for execution or have not enough property to pay off their debts, the persons in charge or the persons dealing with the businesses may be liable for the damages, provided that they have fault in not paying the premium or the overdue charge.

CHAPTER FOUR

Insurance Benefits

Article 31

In case the beneficiaries encounter illness,

injury, or maternity, the contracted medical care institutions shall provide ambulatory or hospital care pursuant to the Medical Benefit Regulations of this Insurance. The physicians may deliver prescription to the beneficiaries for dispensing by the pharmacy.

The Medical Benefit Regulations mentioned in the preceding paragraph shall be drafted by the Competent Authority and submitted to the Executive Yuan for approval before promulgation.

The delivery of the medication mentioned in paragraph 1 shall be made in accordance with Article 102 of the Pharmaceutical Act.

Article 32

To maintain the health of the beneficiaries covered by this Insurance and to enhance medical service in aboriginal settlements, mountain areas, and outlying islands, the Competent Authority shall designate items concerning preventive health services and its implementing rules, and shall establish plans to promote medical service in aboriginal settlements, mountain areas, and outlying islands.

The areas designated as aboriginal settlements, mountain areas, and outlying islands referred to in the preceding paragraph shall be determined by the Competent Authority.

Article 33

The beneficiaries are required to pay 20 per cent of the expenses of either ambulatory or emergency care; 30 percent of the expenses if they visit outpatient departments of district hospitals directly without referral; 40 percent if they visit outpatient departments of regional hospitals without referral; and 50 percent if they visit outpatient departments of medical centers without referral.

The Competent Authority may, when necessary,

sanction the collection of a fixed amount of expenses, which the beneficiaries mentioned in the preceding paragraph 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 first paragraph.

The referral ratio mentioned in paragraph 1 and its implementation date shall be regulated by the central health competent authority.

Article 34

After implementation of this Act, if the national average ambulatory visit exceeds twelve times per person per year for two consecutive years, the deductible system shall be adopted immediately and the regulations for implementation shall be made by the Competent Authority.

Article 35

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 sixtieth 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 beneficiaries 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, shall be determined by the Competent Authority.

The criteria for the establishment of acute care ward and chronic care ward shall be determined by the Competent Authority.

Article 36

In case of the following circumstances, the beneficiaries shall be exempted from payment of the expenses prescribed in Article 33 and 35:

1. Major illness and injury;
2. Child delivery;
3. Receiving preventive health service prescribed in Article 32; or
4. Receiving medical care in mountain regions and outlying islands.

The rules relating to the exemption from the payment of expenses referred to in the preceding paragraph and the scope of illness and injury prescribed in the subparagraph 1 of the preceding paragraph shall be determined by the Competent Authority.

Article 37

In case where the beneficiaries in Category 5 shall pay their own expenses according to Articles 33 and 35, the central competent authority in charge of social affairs shall prepare budget to pay for that; provided, however, those who do not abide by referral provisions prescribed in Article 33 are excluded.

Article 38

The beneficiaries shall pay to the contracted medical care institutions for the self-bearing expenses prescribed in Article 33 and 35.

In case 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.

Article 39

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 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;
 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 promulgated by the Competent Authority not to be covered.

Article 40

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 the government with special aids.

Article 41

No insurance benefits shall be payable to the beneficiaries for any one of the following events:

1. Applying for hospitalization under the same injury or illness after receiving disability benefits under other social insurance laws;

2. Expenses incurred from excessive hospitalization after being notified of discharge from the hospital but refused to do so;
3. Treatment and drug which are not medically necessary according to the pre-examination by the Insurer;
4. Violating relevant provisions of this Act.

Article 42

If medical services provided by the contracted medical care institutions to the beneficiaries were determined by the Professional Peer Review Committee to be incompatible with the provisions of this Act, the expenses thereof shall be borne by the contracted medical care institutions themselves.

Article 43

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.

Article 44

Duplicated payment in cash of benefits under this Insurance for the same incident shall not be allowed.

Article 45

From the date of withdrawal, no benefits shall be payable for the beneficiaries who withdraw from coverage according to Article 11. If the benefits

have already been received, the beneficiaries shall return them to the Insurer. The premium already paid by the beneficiaries shall not be refunded.

Article 46

The right of the beneficiaries to receive cash reimbursement should not be transferred, offset, seized or object to security interest.

CHAPTER FIVE

Payment of Medical Expense

Article 47

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.

Article 48

In order to coordinate and allocate medical payment, the Negotiation Committee for Medical Expenses shall be established consisting of one-third each of the following personnel, with organizational rules of such Committee to be established by the Competent Authority and submitted to the Executive Yuan for approval before promulgation:

1. Representatives from medical care institutions;
2. Representatives from premium payers and specialists or scholars in the relevant fields;
3. Representatives from relevant competent authorities.

Article 49

The Negotiation Committee for Medical Expenses 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 Article 47, and report to the Competent Authority for approval. The Competent Authority shall make decision at its own discretion in case the Negotiation Committee for Medical Expenses 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 payment of the ambulatory care described in the preceding paragraph, according to the ambulatory care services provided by physicians, Chinese medicine doctors and dentists, pharmaceutical services and expense of drugs. Drugs, priced medical devices and materials shall be reimbursed at cost.

The scope of district mentioned in the second paragraph shall be determined by the Competent Authority.

Article 50

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 for Medical Services and the Reference List for Drugs.

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 ambulatory care 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 total of drug expense preset according to the preceding article, a certain ratio of the excessive amount shall be deducted from the budget for the ambulatory care for the current season. In such a situation, the Reference List for Drugs shall be adjusted in the following fiscal year.

The ratio of deduction described in the preceding paragraph shall be decided by the Negotiation Committee for Medical Expenses. The Competent Authority shall make decision at its own discretion in case the Negotiation Committee for Medical Expenses does not reach an agreement in time.

Article 51

The Fee Schedule for Medical Services and Reference List for Drugs shall be established jointly by the Insurer and the contracted medical care institutions and reported to the Competent Authority for approval.

The Fee Schedule described in the preceding paragraph shall follow the principle of "equal payment for same illness" and the relative points shall reflect the cost of each medical service. The International Classification of Diseases shall be used as the reference in deciding equal pay for the same illness.

Article 52

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 practical experiences to organize the Professional Peer Review Committee. The rule of examination thereof shall be established by the Competent Authority.

Article 53

In case the drug, laboratory tests or diagnostic examination is provided by other contracted medical care institutions in accordance with the physician's instruction, and the Insurer, after the examination according to the rules of examination described in the preceding article, decides 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.

Article 54

Articles 47 to 50 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 for Medical Services shall be decided by the Competent Authority.

CHAPTER SIX

Contracted Medical Care Institutions

Article 55

The contracted medical care institutions are as follows:

1. Contracted hospitals and outpatient departments;
2. Contracted pharmacies;
3. Contracted medical laboratory institutions;
4. Other contracted medical care institutions appointed by the Competent Authority.

The regulations governing contract and management matters in respect of the contracted medical care institutions mentioned in the preceding paragraph shall be established by the Competent Authority.

Article 56

The number of the currently operating Government Employees Group Practice Centers shall not be increased. They shall apply the same principles

of equal payment for same illness as the regular hospital outpatient department and bear the risk for surplus or deficit and shall be re-evaluated one and a half years after the implementation of this Insurance.

Article 57

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 total number of hospital wards shall be established by the Competent Authority.

Article 58

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 59

The contracted medical care institutions shall check the qualification of the beneficiaries when they visit. 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.

Article 60

Upon occurrence of an incident under coverage to the beneficiaries, the contracted medical care institutions shall provide proper medical service based on their specialties and facilities without any unreasonable refusal.

Article 61

Before making referral of the beneficiary who needs to be transferred, the contracted medical care institutions shall, in addition to following the provisions of Medical Care Act, complete the summary of medical history for the said beneficiary.

Article 62

In case the Competent Authority or the Insurer requests, for administrative reasons, to investigate, inquire or review relevant documents, such as medical history, diagnosis records, account records, receipts, or cost of medical expenses, the contracted medical care institutions may not elude, reject or obstruct.

CHAPTER SEVEN

Reserve Fund and Administrative Expenses

Article 63

In order to balance the 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.

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

Article 64

The government may impose the social health and welfare surcharge on tobacco and alcoholic products and deposit a proportion of the surcharge collected there from 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.

Article 65

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.

Article 66

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 offer as loans to contracted hospitals for renovation or expansion of the premises;
- 4.To invest in any other program which is beneficial to this Insurance and as approved by the Competent Authority.

Article 67

In principle, the total amount of the reserve fund shall be equal to the total amount of benefit payments in the most recent one to three months based on actuarial principles. The ratio of premium or reserve shall be adjusted when the total amount of the reserve exceeds three months of payments or below one month.

Article 68

The Insurer shall prepare budget for personnel and administrative expenses for this Insurance. The maximum of such budget shall be 3.5 percent of the current annual total amount of medical payment.

The expense of facilities and working capital

required by the insurer for this Insurance shall be paid by the Central Government.

CHAPTER EIGHT

Penal Provisions

Article 69

If a group insurance applicant, which fails to carry out subscription to this Insurance pursuant to Article 16 for the insured or their dependents, it shall be punished with an amount equivalent to two 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 pursuant to Article 30, 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 times of the payable premiums.

Article 69-1

If a beneficiary who, in violation of the provisions of this Act, has not subscribed to this Insurance, he/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 retrospectively 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 70

If a beneficiary subscribes to this Insurance in violation of the provision of Article 12, 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 71

The person who violates the provisions of Article 17, 60 or 61, shall be subject to a fine of no less than two thousand and no more than ten thousand New Taiwan Dollars.

Article 72

The person who receives benefits or claims medical expenses through improper conduct, or makes 0 certification, report, misrepresentation, shall be fined equivalent to twice 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.

Article 73

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, 3 and 6 declared by the insured are less than the regulated insured payroll-related amount.

Article 74

The contracted hospital, if it fails to attain the criteria and the specified ratio of the insurance ward to the total number of hospital ward as provided in Article 57, shall be fined no less than twenty thousand and no more than one hundred thousand New Taiwan Dollars, and shall be

ordered to improve within a given period of time. The fine shall be continuously imposed for each violation if not improved within the time given.

Article 75

The person who violates the provision of Article 58 shall return the amount received and shall be fined five times of the expenses received.

Article 76

The person who violates the provision of Article 62 shall be fined an amount no less than ten thousand and no more than fifty thousand New Taiwan Dollars.

Article 77

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

Article 78

In case the fines imposed by this Act remain unpaid after a given period of time provided in the written notice, the case shall be referred to the court for compulsory execution.

CHAPTER NINE

Supplementary Provisions

Article 79

The Insurer may offer incentive to the group insurance applicants and the beneficiaries who have achieved significant result in the practice of preventive health care. The regulation of incentives shall be established by the Insurer and reported to the Competent Authority for approval.

Article 80

The Competent Authority, for the purpose of mediating insurance disputes or the Insurer, and implementing the underwriting business or reviewing medical claims, may inquire the tax authority or other relevant authorities for documents relevant to the insurance of the beneficiaries.

Article 81

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

Article 82

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

1. In Motor Vehicle Traffic Accidents: the Insurer of motor vehicle's compulsory third party liability.
2. In Public Safety Accidents: the Insurer of compulsory third party liability.
3. In the 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 insurance, the tortfeasor himself or herself.

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

Article 83

The financial revenue and expenditure of this Insurance shall be administered by the Insurer as operation fund in the annual fiscal budget.

Article 84

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

Article 85

The Competent Authority, within two years after implementation of this Insurance, shall prepare evaluation report and improvement proposal for the National Health Insurance. The improvement proposal shall include suggestions for alternative sources of funding, premium burden of the insured, and organizational form of the insurer.

Article 86

The Enforcement Rules of this Act shall be prepared by the Competent Authority and submitted to the Executive Yuan for approval before promulgation.

Article 87

Article 69-1 shall be applied to the Insured in item 2 of Category 6 one year after implementation of this Insurance.

Article 87-1

The overdue charge, the suspension of benefits and of the insurance card, or the fines provided in paragraphs 1 and 4 of Article 30, paragraph 2 of Article 38, and Article 69-1 are not applicable to the insured qualified as being financially difficult under Article 87-5.

Article 87-2

The Competent Authority may work out a budget or borrow a certain amount of money from the reserved fund of this Insurance to establish a fund for the insured, who have financial difficulty in paying premiums under Article 87-5, to apply for loans without interest in the amount of the premiums of this insurance and the fees they have to pay. The Executive Yuan shall establish the regulations governing the revenue and expenditure of the fund and the ways in which the fund is managed and used.

The regulations concerning the qualifications for applying for loans from the fund provided

for in the preceding paragraph, conditions for granting loans, the duration of repayment, the ways of repayment, and any other regulations to be obeyed, shall be established by the Competent Authority. Nonetheless, the amount of repayment shall 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 at their own will.

The Competent Authority shall make budgetary plan for payment to the insurer of the interest on the fund borrowed from the reserve fund of this Insurance referred to in paragraph one.

Article 87-3

For those remained uninsured, who are subjected to financial difficulty or are unable to pay the premiums, the Competent Authority shall order the Insurer, or the group insurance applicants to help them finish the enrollment procedures.

Article 87-4

Those who met the qualifications as being financially difficult under article 87-5 and did not subscribe to this Insurance prior to June 6, 2003 when this law was revised, shall pay their premiums from the date of subscription due, and are entitled to apply for postponing paying the premiums due prior to their new subscription, if they subscribe to this Insurance within one year after June 6, 2003. Nonetheless, for those who did not subscribe to this Insurance over four years after March 1, 1995 when this Insurance was established, and met the qualifications as being financially difficult under article 87-5, the premiums prior to their subscription to this Insurance are waived, and the medical expenses paid by themselves previously cannot be reimbursed.

The insured that have applied a loan for their relevant fees under article 87-2 may apply for

postponing their payments within a year after June 6, 2003, the date of this Act's revision.

For the beneficiaries of this Insurance who applied for postponing their payments for either their premiums or their loans under the preceding two paragraphs, the Insurer has to periodically check their abilities to repay. For those who have the ability to repay but refuse to do so after the Insurer informs them to pay in writing, the Insurer may refer the case to the court for compulsory execution under the law.

Article 87-5

The Competent Authority shall establish the regulations as to identifying the people being financially difficult and being the particularly financially difficult mentioned in article 87-1, 87-2, and the preceding article.

Article 88

The date of implementation of this Act shall be effective upon promulgation, unless otherwise indicated.

Article 89

Two years after the implementation of this Act, the Executive Yuan shall amend this Act within half a year; otherwise, this Act shall cease to be effective upon such expiration.



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