Chapter 7.

National Health Insurance

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The National Health Insurance is the maximum security protection network for the maintenance of health and welfare of the people. Since the inception on March 1, 1995, under the joint efforts of the government, the employers, the medical industries and the public, the economic barriers of the public to medical care have been greatly reduced, and the accessibility to medical care has been significantly increased. The public approval rate has always remained high around 70 to 80%. The values created by the NHI have been the object of study by many countries, and in the year 2005 alone, visitors from some 40 countries had visited Taiwan to study the program. The Health Affair, a leading international journal in global health sciences and services, in a research paper published in 2003 on the National Health Insurance of Taiwan states that by the equity index of financial sharing of the World Health Organization, the ratio of medical expenditures of Taiwan's National Health Insurance to the disposable incomes of households, that is equity of financial sharing, ranks the first in the world, and is better than that of many developed countries. This chapter focuses on the current status of the National Health Insurance and the reform of the program.

Section 1. Current Status of the National Health Insurance

The National Health Insurance was initiated on March 1, 1995. It is the most important social construction since the start of the Republic. For the sustainability of the program and to protect the rights of the people to medical care, a number of measures have been taken.

1. Current Status of Insurance Underwriting

The National Health Insurance is a mandatory social insurance in that every citizen of the Republic of China who has registered in the Taiwan Area for more than four months is required to join the program to be the target population of the program. Aliens who are issued residence permits, and have resided in the Taiwan Area for more than four months, shall also, by law, join the program. To attain the goal of universal coverage, and to provide the entire population with adequate medical care, various supervisory measures have been taken to improve the insurance underwriting. By the end of 2005, a total of 22,314,647 people were covered, giving a coverage rate of 99%, the goal of universal coverage is almost attained.

To protect the rights to medical care of the less privileged groups and to lessen their economic burdens, various measures have been taken.

1) Subsidies to the insurance premiums: Individuals of the less privileged groups, the low-income families, the physically and mentally impaired, the elderly 70 years and above of the medium-income families, unemployed indigenous peoples, unemployed laborers, children under 3 years of the medium and low-income families are subsidized of their insurance premiums. Each year, approximately NT$ 6.6 billion is spent to subsidize some 1.11 million people.
2) Assistance to individuals with overdue premiums
   (1) Payment by installment: Individuals cannot, for economic reasons, pay insurance premiums in full at one time, may pay them in installment to alleviate their pressure on insurance underwriting. By the end of 2005, 170,625 persons had joined this arrangement for a total of NT$ 5.773 billion.
   (2) The National Health Insurance Relief Fund: Individuals, who are qualified by the provisions of the regulations governing identification of individuals of economic difficulty or extreme economic difficulty, may apply to the National Health Insurance Relief Fund for loan without interest and paying it back a year later. By the end of 2005, 7,856 applications had been approved for a total of NT$ 493 million.
   (3) Referral to charity groups for donations to pay overdue insurance premiums: Branch bureaus of the Bureau of National Health Insurance will refer people unable to pay insurance premiums to charity groups or individuals to pay for their premiums. By the end of 2005, 698 cases had been referred for a total of NT$ 5.64 million.

3) Provision of measures for emergency care protection: To protect the rights to medical care of those who are unable to pay insurance premiums and yet are in urgent need for emergency care, hospital care, and outpatient care for acute or severe illnesses and injuries, if they are in possession of proof of low income issued by the neighborhood chiefs or the medical care institutions that they are visiting after investigation, they may be first medically cared as the insured. The branch bureaus of the Bureau of National Health Insurance will, acting on their needs, help apply to the National Health Insurance Relief Fund for loans without interest, refer them to charity groups for payment of insurance premiums, or coordinate contracted hospitals to absorb the medical costs in their medical care aid funds to help solve their problems. By the end of 2005, 1,234 cases had been accepted for total medical costs of NT$ 19.21 million.
4) Reducing financial burdens of patients of severe illnesses and injuries: Patients of cancer, chronic psychiatric diseases, hemodialysis, congenital disorders and rare diseases, their co-payments for medical care are waived. There are 560,000 some such cases. Although they account for a mere 2.9% of the total insured, their share of the medical care resources in 2003 alone was NT$ 85.9 billion, and accounted for 24% of all medical costs.
5) The rights to medical care and medication of severely ill patients of rare diseases, hemophilia and AIDS are assured.

2. Insurance Financing

When the National Health Insurance was initiated in 1995, the premium rate was set at 4.25%. This was an average rate calculated actuarially on a five-year cycle basis. For factors such as the slowdown of economic development, aging of population, advancement in medical science and technology, and improvement in medical care quality, since 1998, revenues from insurance premiums have lagged behind the growth of medical costs to result in the imbalance of the Insurance finance. The various revenue-increment and expenditure-saving measures and the strict monitoring of financial affairs executed by the Bureau of National Health Insurance had prolonged the financial balance originally set for five years to September 2002 when the premium rate was slightly adjusted from the original 4.25% of 4.55% to maintain the minimum financial balance for the next two years.

Between March 1995 and end of 2005, the insurance revenue, calculated on the actuarial basis, was NT$ 3,133.26 billion, whereas the insurance cost was NT$ 3,131.87 billion. In the year 2005 for instance, the insurance revenue was NT$ 361 billion, whereas the insurance cost was NT$ 367.427 billion, giving a deficit of NT$ 6.427 billion; the cumulative reserve funds were NT$ 1.423 billion, lower than the amount of one month total insurance payments (about NT$ 30.6 billion). By regulations of Article 67 of the National Health Insurance Act, the premium rate shall be adjusted when the total amount of safety reserve is lower than the amount of one month total insurance payments (see Table 7-1 and Figure 7-1 for details).

To maintain the financial balance of the National Health Insurance and thus to provide the public with high-quality medical care services, the Bureau of National Health Insurance, since March 2004, has held meetings with the public for the general sharing of opinions. In January 2005, a public hearings meeting was held. Acting on resolutions of the public hearings meeting and questionnaire survey of various groups, a "pluralistic micro adjustment"plan was adopted to stress equally on "revenue-increment and expenditure-saving", and to continue to implement such measures to somehow ease the financial conditions of the program.

Revenue-increment measures:

1) Public health related expenditures such as preventive healthcare, control of notifiable diseases, and teaching expenses of teaching hospitals will be borne by government budgets. On August 10, 2005, a total of NT$ 4 billion was approved by the Executive Yuan.
2) The upper ceiling mandated for insurance subscription will be adjusted upward from the current NT$ 87,600 to NT$ 131,700. This was implemented on April 1, 2005.
3) The ratio of the amount mandated for insurance subscription to total salary of the military and government employees will be adjusted upward from the current 82.42% to 87.04%. This was implemented on April 1, 2005.
4) The amendment of the Tobacco and Alcohol Revenue Act was approved by the Legislative Yuan

Table 7-1 Revenues and Expenditures by Year of the National Health Insurance (by Responsibility)

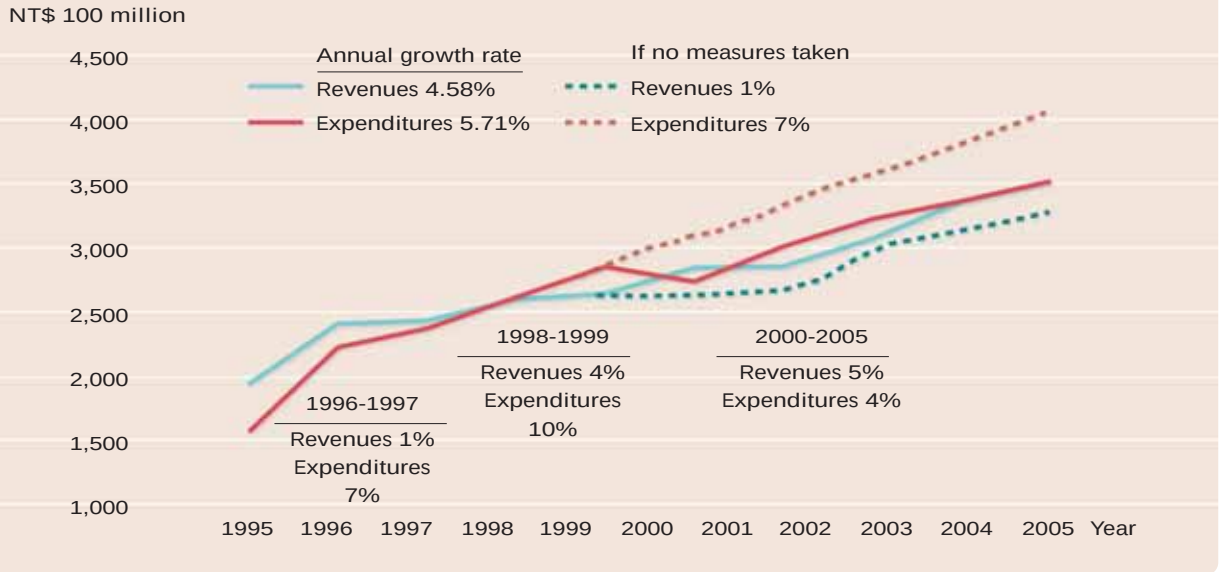
unit：NT¢C100 million

Year	Revenues[1]		Costs[2]		Balance	Surplus of Safety Reserves
	Amount	Growth Rate (%)	Amount	Growth Rate (%)		
1995	1,939.91	-	1,568.47	-	371.44	371.44
1996	2,413.27	-	2,229.38	-	183.89	555.33
1997	2,436.40	0.96	2,376.14	6.58	60.26	615.59
1998	2,604.81	6.91	2,620.40	10.28	(15.59)	600.00
1999	2,648.94	1.69	2,858.98	9.10	(210.04)	389.96
2000	2,851.70	7.65	2,842.06	(0.59)	9.64	399.60
2001	2,861.46	0.34	3,017.88	6.19	(156.42)	243.18
2002	3,076.07	7.50 [3]	3,232.62	7.12	(156.55)	86.63
2003	3,367.60	9.48	3,371.43	4.29	(3.83)	82.80
2004	3,522.44	4.60	3,526.74	4.61	(4.30)	78.50
2005	3,610.00	2.49	3,674.27	4.18	(64.27)	14.23
Total	31,332.60	-	31,318.37	-	14.23	
Annual average 1996-2005	2,939.27	4.58	2,974.99	5.71	-	

Explanations : 1. ( ) is for negative values
2. Revenues and expenditures for 1995-2004 are audited balances.

Notes : 1. Insurance revenues = Insurance premiums + fines on overdue payments + net incomes from capital use + share of public-interests lottery + other net incomes - bad debts
2. Insurance costs = medical costs + other financial insurance costs (subsidies on medical care for the September 21 earthquake already deducted)
3. Insurance premium base expanded in August 2002; since September 2002, premium rate is adjusted from 4.25% to 4.55%

Figure 7-1 Financial Balances by Year of the National Health Insurance



on January 3, 2006. The health tax on tobacco products is adjusted upward from the current NT$ 5 to NT$ 10 per pack. The share of the revenue for the National Health Insurance reserves has been adjusted upward from the current 70% to 90%.

5) The scope of subrogation has been extended from occupational hazards to public security, serious traffic accidents, food poisoning and incidents of public hazards. This amendment was approved by the Legislative Yuan on April 29, 2005.
6) Differences in co-payment between primary care institutions and large-scale hospitals have been enlarged. Since July 15, 2005, co-payment is adjusted upward for patients of western medicine who visit hospitals without prior referral.

Expenditure-saving measures:

1) Using information of the IC card to help and check upon frequent users of medical care.
2) Reducing repeated laboratory testing, examinations and medication.
3) Monitoring drug prices to narrow price differences.
4) Strengthening inspections of violations of hospitals.
5) Intensifying education of the public on correct medical care and safe use of drugs.

3. Payment System

Payment schedules for medical costs under the National Health Insurance are reviewed and amended constantly to improve the quality of medical care, to reasonably reflect the comparative values of the payment points, and thus to promote the balanced development of various departments and hospitals at various levels. Major adjustments include: the second edition of the medical payment schedules based on comparative values has been compiled to agree to include obstetrics and gynecology tables of comparative values in the payment schedules; on the principle of equal pay for equal work, amendment is made on the basis of one single table to agree with the western medicine primary care institutions to propose items for relaxation for the second stage, totaling seven items; to reduce differences in payments by day for hospice care at different levels, amendment is made for single payment, and the pilot project to include hospice care in the National Health Insurance payments is approved to pay on a single point basis at a fixed amount for each day for institutions at all levels; to protect the rights of the public on the use of medicines, claims at cost for drug for pain of bony metastasis, bisphosphonate, are added; to upgrade the quality of primary care, plans for the improvement of hypertension and depression have been added; to save medical expenditures, unreasonable release of prescriptions by clinics is formed, and regulations concerning the management of pharmacies by capitals invested by pharmacists are excluded; to strengthen dental care services for the physically and mentally impaired, regulations are relaxed to make services available for the moderately and above impaired, and county/city dental associations may form dental care teams to visit on fixed schedule social welfare institutions for the physically and mentally impaired designated by the Ministry of the Interior for dental care services; to encourage physicians to perform natural delivery in place of Caesarean section, since May 1, 2005, payments for natural delivery are adjusted to the same level of case-payment for Caesarean section. In addition, action is being taken to promote the DRG payment for hospital care.

To reasonably contain medical costs, and to promote the balanced distribution of medical care resources, since July 2002, the global budget payment system has been universally implemented. At the micro-level, the payment schedules and the claim review system have been reformed. Measures include payments for quality of service rendered (such as a plan to improve payments for five major diseases, and a pilot project on integrated medical care by family doctors), expansion of the case payment system, and study on the formulation of a table of payment schedules based on comparative values. The case-by-case review has been shifted toward the establishment of medical care pattern review based on profile analysis.

In accordance with regulations of the National Health Insurance Act, the global budget for the year is proposed by the Department before the start of a fiscal year. After approval by the Executive Yuan, the budget is referred to the NHI Medical Expenditure Negotiation Committee, which will call the payers and the healthcare providers to a meeting to reach an agreement on the total amount and the way of allocation. The results of negotiation by year are shown in Table 7-2.

To improve the quality of medical care for the insured, the Bureau of National Health Insurance has

contracted many medical service institutions around the country. By the end of 2005, there were 22,965 institutions signed contract with NHI, of them, 17,931 are medical care institutions, 4,171 pharmacies, 24 midwifery clinics, 118 community psychiatric rehabilitation institutions, 465 home care institutions, 222 medical laboratories, 28 physical therapy centers, and 6 medical radiological therapy institutions. In 2005, the average number of outpatient visits per person per year was 14.84 times, a slight decline as compared to the 14.71 times of the previous year.

The National Health Insurance also provides six preventive healthcare services namely, health promotion for children, health promotion for adults, Pap smear examination for cervical cancer, prenatal care for pregnant women, breast examination for women 50 years and above, and dental healthcare for children. By the end of 2005, the utilization rates of these services were 73.12%, 35.39%, 29.47%, 96.84%, 3.05% and 6.25%, respectively.

To improve the quality of drug use of the public, to make available more choices for drug use, and reduce the financial burdens of the public, regulations on the payments of drugs have been adjusted one by one in the recent years. In 2005, payment regulations were adjusted for the following items: drugs for osteoporosis, drugs for recurrent malignant multiple sclerosis, drugs for middle-stage atoipc dermatitis, oral drugs for stomach cancer patients, drugs for intrusive candidiasis, antiplatelet drugs, drugs for recurrent multiple sclerosis, and drugs for primary pulmonary hypertension.

4. Medical Payments

1) Review of Claims for Medical Costs

The review of claims for medical costs submitted by medical care institutions comes in procedure review and professional review. The procedure review is made by the administrative staff to check the accuracy of the information on the claims, and to make sure whether the claims meet the various payment regulations of the payment schedules. To handle the enormous amount of claims, some procedure review has been standardized by computers. In the process of the professional review, claims are either randomly or intentionally sampled through computers by the Bureau of National Health Insurance. Medical and pharmaceutical experts with experience in teaching, clinical care, or practical experience are invited by the Bureau to form medical care service review committee and regional medical care service review sub-committees to review these sampled claims. For disciplines practicing the global budget payment system, their professional review may be commissioned to relevant medical institutions or groups such as the National Union of Physician's Associations. To improve the consistency of review, at the end of 2005, principles on the review of medical care services by global budget were amended and supplemented for the review of medical costs.

Table 7-2 Growth of Medical Expenses per Person per Year

Year		2002		2003	2004	2005	2006
By section		1st Half Year	2nd Half Year				
Ranges approved by the Executive Yuan		1.67~4%	1.55~4.02%	0.51~4.00%	1.34~4.03%	1.17~5.00%	
Total		2.342~3.707%	3.883%	3.899%	3.813%	3.605%	4.536¢H
Coordinated by the NHI Medical Expenditures Negotiation Committee	Dental outpatient	2.50%		2.48%	2.64%	2.90¢H	2.93¢H
	Chinese medicine outpatient	2.00%		2.07%	2.41%	2.51¢H	2.78¢H
	Western medicine primary care	3.727%		2.898%	2.70%	3.228¢H	4.684¢H
	Hospital	1.61~3.727% (Target)	4%	4.01%	4.10%	3.53¢H	4.90¢H
	Others	—		increase 1.3 billion	increase 1 billion	increase 1.141 billion	increase 0.062 billion

Explanation : The first stage of the global budget payment system for the western medicine primary care was implemented from July 2001 to December 2002; the first stage of the global budget payment system for hospitals was implemented from July to December 2002

To assure the safety of medical care, and to avoid any hazards to health or life of patients caused by the inadequate use of drugs, examinations, operations or medical treatment by a few physicians; to promote the effective utilization of medical care resources, and to assure that the insurance premiums paid by the people are used effectively and correctly, the Bureau of National Health Insurance has invited the medical indusfries to develop a set of criteria to withhold payment for claims reviewed through profile analysis. A threshold value is set for each criterion. When the threshold is exceeded, deduction of payments is made on the claims submitted by the medical care institutions through computers. Through this professional management procedure and follow-up monitoring, it is hoped to correct abnormal medical behavior and to assure the reasonable utilization of medical care resources. In 2005, non-payment criteria had been announced for 16 items.

The review and administrative relief procedures of the National Health Insurance medical costs come in initial review, reply, re-deliberation, dispute mediation, appeal and administrative litigation. The initial review is made by procedure review and professional review. The rates of reduction of outpatient and inpatient medical costs by year are shown in Table 7-3. If the medical care providing institutions are in disagreement with the results of the review on medical costs, they can apply for reply. Applications for re-deliberation can be made if they are not satisfied with the results of the reply. Re-deliberation is made by the NHI Dispute Mediation Committee of the Department.

To improve the functions of dispute mediation, acting on the principles of assuring the quality of medical care and at the same time containing the financing and respecting the professional autonomy of medical care and the rights of patients, an evidence-based review system and principles of common review have been established to upgrade the quality of medical care through ethics, laws and analysis of economic policies.

2) Review of Quality of Medical Care

(1) The global budget payment committees of various disciplines are coordinated to decide on two or three indicators for some specialty items of higher popularity and feasibility. These indicators are published on the Internet for the public to know about the quality of medical care. More will be done to coordinate the global budget payment committees of various disciplines to increase the number of indicators that can be published, to study the cost-benefit and the feasibility of other ways of publication, and thus to provide the public with the information they actually need. Currently, reports completed for indicators of the professional medical care service quality, case analyses, literature on evidence medicine, guidelines for clinical care and education and training materials have been published on the Internet or in print form for the reference of all. Since November 21, 2005, a special zone, °ßMedical Care Quality All Revealed", has been set up on the global information network of the Bureau of National Health Insurance to publicize quality information by hospitals and clinics. Thus far, the site has been visited

Table 7-3 Reduction Rates after Review of Claims for Outpatient and Inpatient Medical Costs

Year	Total Reduction Rate after Initial Review	Total Reduction Rate after a second Review	Total Reduction Rate after a Dispute Mediation
1997	3.28¢H	2.34¢H	2.21¢H
1998	2.73¢H	1.96¢H	1.81¢H
1999	3.48¢H	2.75¢H	2.53¢H
2000	3.97¢H	2.34¢H	2.15¢H
2001	2.45¢H	1.89¢H	1.69¢H
2002	2.21¢H	1.67¢H	1.54¢H
2003	1.27¢H	1.03¢H	1.01¢H
2004	2.38%	2.14%	2.12%

48,083 person-times. Items of indicators publicized are as follows.

a) Hospital global budget: three indicators, labeling of name of drug and instruction for use on drug pack, registration fees for general outpatient clinics, and percentage of prescriptions for continuing use written for chronic diseases.

b) Western medicine primary care: three indicators, use rate of injections, re-visit rate of patients to outpatient clinics for upper respiratory tract infections, and repetition rates of days of drug use at outpatient clinics.

c) Dental care global budget: two indicators, two-year survival rate of dental fillings, and one-year rate of root canal therapy .

d) Chinese medicine global budget: two indicators, rate of repetitive use for more than two days for prescriptions for more than seven-day use, and rate of repetitive visits to Chinese medicine care.

(2) Reports on medical care quality for each global budget discipline is produced quarterly and published on the professional medical care quality zone of the global information network of the Bureau for the reference of all. In addition, reports on the professional medical care quality of cataract, the new-generation NSAID, diabetes, hypertension, artificial joint replacement, analysis of the days of use of antibiotics, and specific diseases in mountain areas and offshore islands or their treatment methods have been completed and are either printed or published on the Internet for the reference of all.

Section 2. Reform of the National Health Insurance System

The National Health Insurance is the most important social construction since the start of the Republic. It is also a public policy that has benefited most people. It is also an important link in the promotion of national development, maintenance of social security and protection of the rights of the people. For the rapid aging of population, and the high costs of high-tech medical care, medical expenditures have exceeded revenues from insurance premiums. Adjustment of the premium rates, their contribution bases and medical care payments is not easy. On top of these, there are the threats of the emerging communicable diseases; these and other factors have made the National Health Insurance face financial risks. To meet the challenges, reform of the national health insurance system has been promoted vigorously to assure the sustained management of the National Health Insurance.

1. Reasons for Reform

The National Health Insurance is the pride of us all. The implementation of policies must, however, make progress constantly. For the sustainability of this social insurance scheme, and at a time the current system is facing many problems and dilemmas, the reform of the system is imperative under the circumstances. To reform the system, one must first review the problems and dilemmas currently encountered with the full participation of the entire population. The voices of the public, the private sector groups and the medical groups are all important reference for the reform.

Dilemmas Encountered Currently

1) The worsening financial situation: For factors such as the aging of population, advancement in medical technologies, and the increasing demands of the people, revenues of the National Health Insurance have been, for some time, lagged 2% behind the expenditures. The pluralistic micro-adjustment though can barely maintain the financial balance for a period of time, at a time the safety reserves are reaching the bottom, the issue of financial balance must with priority be dealt with.

2) Differences in premium contributions: The current system classifies in detail the insured into 14 items in six categories. Premium contribution rates are different for each item and each category to cause large differences in the sharing of premiums. The self-paid premiums of the unemployed without incomes (the sixth category) are higher than those of union members with fixed incomes, the farmers, and the fishermen (categories 2 and 3). Families with more dependents pay more. All these are in violation of the "sharing by ability to pay" principle stressed by social insurances.

3) Insufficient linkage of revenues and expenditures:

Currently, the revenues of the National Health Insurance are supervised by the NHI Supervisory Committee, and the expenditures are negotiated by the NHI Medical Expenditure Negotiation Committee. There is no such mechanism to link revenues and expenditures to result in the imbalance of the insurance financing.

4) Insufficient mechanisms for the allocation of resources: The National Health Insurance is a merger of the original government employee's, laborer's and farmer's insurance schemes, and there is a lack of an assessment mechanism for the scopes of payments. When there is no coordination between revenues and expenditures, the mechanisms for the allocation of medical care resources are short in supply to result in the wastes of medical care and difficulties in the adjustment of the contents of payments.

5) Medical care information not transparent enough: For the inequity in medical care information, the public are unable to judge the quality of the medical care services they receive. People often depend highly on the advices and referral for medical care of their friends and relatives, the lack of medical care information or difficulties in their interpretation have become more serious.

6) Payments should focus on quality: Currently, payments are mostly made on quantity basis. Very little consideration is given to the quality of medical care. Medical care institutions, under the twofold pressures of costs and management dilemmas, often overuse medical care resources. Therefore, the payment mechanism should give more consideration to the upgrading of quality.

2. Goals and Core Values of the Reform

The NHI Second-Generation Task Force of the Executive Yuan has, after several years of planning, submitted a final report. The report contains policy recommendations in four aspects, strengthening the provision of information to enhance the quality of medical care, balancing the finances and improving service purchasing efficiency, expanding diversified social participation in NHI policies, and constracting an accountable NHI organizational system. The Department has, on this basis, actively planned for the amendment of laws and regulations for the second-generation insurance scheme.

1) Goals of reform: to assure the reliability of medical care, to upgrade quality, efficiency and equity.

2) Core values

Quality: to promote the publication to the public of information on medical care and medical care quality to allow them more choices; to strengthen mechanisms in upgrading the quality of medical care; payment systems will be reformed toward the direction of encouraging high-quality medical care.

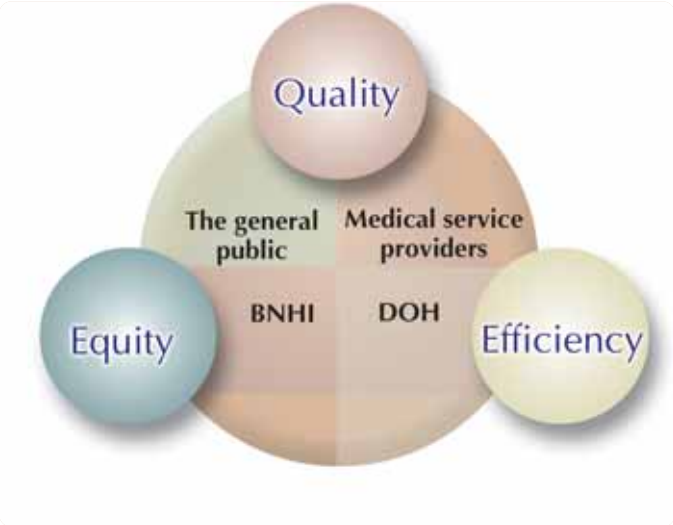
Equity: Insurance premiums will be collected upon the total incomes of the family; people of low-income are guaranteed medical care following the current system. People of high-income share more premiums. Households of same incomes share the same premiums.

Efficiency: Classification of the insured will be modified from the current 14 items in six categories to two categories. When individuals change jobs or have a salary adjustment, they are no longer required to change their insurance status. The two committees will be merged to promote a mechanism to link revenues and expenditures.

3. Major Points in the Amendment of Laws

To link with the Second-Generation National Health Insurance, the Department has taken action to amend the National Health Insurance Act based on the core values of quality, equity and efficiency. Action has also been taken to reform the structure of the National Health Insurance system based on the concept of accountability. Through the provision of information, quality of medical care is upgraded. A fair method will be adopted to collect insurance premiums, and the contribution bases will be enlarged. A linking mechanism for revenues and expenditures will be set up. A more pluralistic social participation in health insurance policies will be encouraged. Also, with reference to the comments on the current regulations of the National Health Insurance pointed out by the Grand Justice of the Judicial Yuan in their interpretations No. 524 and No. 533, and also in coordination with the relevant regulations of the Administrative Procedures Act, articles concerned will be amended and supplemented.

In 2005, some 200 meetings for communication were held with ministries and departments concerned, local governments and relevant organizations and



groups, and visits were made to caucuses of ruling and opposition parties to solicit their opinions, with a hope that the reform will meet the expectation of the people. Major points in the amendment draft are as follows.

1) Organizational Structure and Social Participation
   (1) The NHI Supervisory Committee and the NHI Medical Expenditure Negotiation Committee will be merged into the NHI Supervisory Commission.
   (2) Power to manage insurance revenues and expenditures will be unified; the linking mechanism between revenues and expenditures will be strengthened.
   (3) Representatives of the payers will join in deciding on the scopes of payments and the insurance premiums to be shared, and thus to calculate the insurance premium rate.
   (4) The NHI Supervisory Commission, when reviewing or negotiating major issues related to insurance, and when extended participation is considered necessary, may first organize relevant citizen's participation activities.

2) New Insurance Premium Scheme
   (1) The contribution bases will be extended from salaries to the total incomes of the family.
   (2) Total funds required by the insurance will be shared by the government, employers and the insured. The share of the government will be calculated of its growth rate by a certain formula; the employers share the premium by a certain formula, and their share is linked with that of the insured; the insured share the premium by the total incomes of the family.
   (3) Classification of the insured will be simplified from 14 items in six categories to two categories.
   (4) The insuring agent shall, each year, submit to the NHI Supervisory Commission for review, the upper and lower limits of the insurance premiums of the insured, the contribution rate of the premium due, and the average share ratio between the employers and the employees. These matters will be announced by the competent authority each year.
   (5) No move-in/move-out processing is required for any changes of status of the insured within the insuring agents. Processing is required only at time of subscribing to or withdrawal from the program.
   (6) Procedures for insurance funds, collection of insurance premiums, payment of premiums, accounting, and collection of payment overdue will be changed.

3) Medical Quality and Information Disclosure
   (1) To assure the quality of medical care, the insuring agents and the insurance medical service institutions will periodically make known information on medical care related to the insurance.
   (2) Payment by quality will be strengthened.
   (3) Ways and procedures to formulate "items of payments and payment schedules for medical care services", and "items of payments and payment schedules for pharmaceuticals" will be established.
   (4) Contracted medical service institutions, when their claimed medical costs exceed certain amount, should supply financial reports related to the National Health Insurance; the reports may be publicized by the insuring agents.

4) Others
   (1) There should be a waiting period for those who have stayed overseas for some long time.
   (2) To provide the public with more choices for medical care, payment for differences will be decided. That is, the insured may decide to use medicines the prices of which are higher than the upper limit of the payment, and pay for the differences. Items and time of implementation will be reviewed by the NHI Supervisory Commission.