Key Terminology

The National Health Insurance Act and the Regulations Governing Contracting and Management of NHI Medical Care Institutions mentioned in this section refer to the provisions announced on June 29, 2011 and December 28, 2012.

1. Enrollment and Underwriting

● Group Insurance Applicants

According to Article 15 of the National Health Insurance Act

The group insurance applicants for the different Categories of the insured are as follows:

(1) For the insured in Categories 1 and 2, the group insurance applicants shall be the agencies, schools, enterprises, institutions, or employers, which they work for, or unions where they hold membership. Nonetheless, the group insurance applicants that cover the insured in the Ministry of 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 10, the group insurance applicants shall be designated by the Ministry of Defense.

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

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

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

● Beneficiaries

This refers to the insured and his/her dependents.

According to Article 10 of the National Health Insurance Act

The insured shall be classified into the following six categories:

(1) Category 1

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

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

iii. Employees other than the insured prescribed in the preceding two items 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 Seaman'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 age for enlisting in the military, who are currently in military-substitute service.

iii. Those who are serving sentences in correctional institutions or receiving punishments from police and military court-martial. However, this is not applicable to those who are serving sentences of less than two months or are under parole.

(5) Category 5

Members of a household of low-income families as defined by the 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.

According to Article 2 of the National Health Insurance Act, dependents refers to:

(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.

● The Insured Payroll-Related Amount

According to Article 19 of the National Health Insurance Act:

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

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

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

According to Article 20 of the National Health Insurance Act:

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

(1) Employees: the payroll;

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

(3) Self-employed individuals and independently practicing professionals and technicians: the income from professional practice.

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

According to Article 22 of the National Health Insurance Act:

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

According to Article 23 of the National Health Insurance Act:

The premium of the beneficiaries in Categories 4 to 6 shall be calculated according to the

averaged actuarial premium based on the total number of the beneficiaries in accordance with Article 18. The premium of the dependents stated in the previous paragraph shall be paid by the insured. When the number of the dependents exceeds 3, the payment shall be calculated on the basis of only three dependents.

● The Average Insured Payroll-Related Amount

The Average Insured Payroll-Related Amount is calculated as follows:

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

● NHI Premium Contribution Proportions

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

Category of Beneficiaries			Percentage (%)		
			The Insured	Group Insurance Applicants	Government
Category 1	Civil Servants, Voluntary Military Personnel, Government Employees	The Insured and Dependents	30	70	0
	Private School Faculty and Staff	The Insured and Dependents	30	35	35
	Employees with Certain Employer(s) in Public or Private Enterprises or Institutions	The Insured and Dependents	30	60	10
	Employers, Self-employed Business Owners, Independently Practicing Professionals and Technicians	The Insured and Dependents	100	0	0
Category 2	Occupational Union Members Without Specific Employers, Alien Seamen	The Insured and Dependents	60	0	40
Category 3	Farmers, Fishermen, and Members of Irrigation Associations	The Insured and Dependents	30	0	70
Category 4	Military conscripts, Military school students on scholarships, Widows of deceased military personnel on pensions, Males performing alternative military service, Inmates at correctional facilities	The Insured	0	0	100

Category of Beneficiaries			Percentage (%)		
			The Insured	Group Insurance Applicants	Government
Category 5	Low-income Households	The Insured	0	0	100
Category 6	Veterans, Household Representatives of Survivors of Veterans	The Insured	0	0	100
		Dependents	30	0	70
	Other District-level Residents	The Insured and Dependents	60	0	40

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

(1) Contribution from the insured and dependents:

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

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

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

Average premium × Contribution rate × Number of dependents

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

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

(2) Contribution from group insurance applicants:

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

(3) Contribution from government subsidies:

i. The beneficiaries in Items 1 to 3 of Category 1:

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

ii. The beneficiaries in Categories 2 and 3:

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

iii. The insured in Categories 4, 5, and Veterans in Item 1 of Category 6 (entirely subsidized by the government):

Average Premium × Actual number of the insured

iv. The beneficiaries in Category 6 (Veterans in Item 1 exceluded):

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

When the number of dependents exceeds 3, the payment shall be calculated on the basis of only three dependents. The number of dependents in Items 1 to 3 of Category 1 shall be the average number of the dependents that the insured in Items 1 to 3 of Category 1 actually have. The average number of dependents is set at 0.7 in 2014.

2. Financial Status

● Premium Receivables

This refers to the premium amounts that are receivable each month (year). They do not include supplementary premiums, the shortage of the 36 percent of the annual health insurance budget, the lowest amount which should be burdened by the government according to law, and delinquent charge receivables.

● Premiums Collected

This refers to the premiums that are received with receipt each month (year). They do not include supplementary premiums, the shortage of the 36 percent of the annual health insurance budget, the lowest amount which should be burdened by the government according to law, and delinquent charge collected.

● Collection Rate

(Premium Collected / Premium Receivable) × 100

● Statutory Government Subsidies

This refers to the premium paid by government pursuant to Article 27 of the National Health Insurance Act.

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

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

● Supplementary Premium

This refers to the premium collected pursuant to Articles 31 and 34 of the National Health Insurance Act.

● Income from Medical Service Provision

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

● Delinquency Charges

Delinquency charges shall be calculated as 0.1% of the amount to be paid for every one day delayed for group insurance applicants, beneficiaries and premium withholder. However, the maximum delinquency charge is capped at 15%; small delinquency charges under a certain amount, as determined by the competent authority, do not have to be paid. The Executive Yuan announced on May 21, 2012 that the cap of the maximum delinquency charge paid by the insured pursuant to Article 35, Paragraph 1, Subparagraph 2 of the National Health Insurance Act, which was implemented on July 1, 2012, would decline from 15% to 5%.

● Collection Rate of Delinquency Charges by Number

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

● Collection Rate of Delinquency Charges

(Delinquency Charges Collected / Delinquency Charge Receivables) × 100

● Reserve Fund

According to Article 76 of the National Health Insurance Act

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

(1) Surplus from each fiscal year;

(2) Premium overdue charges of this Insurance;

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

(4) Social health and welfare surcharge on tobacco and alcoholic products imposed by the government.

(5) Incomes from sources with statutory grounds other than this Act.

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

● Added Social Health Insurance Contributions for Tobacco

According to Article 4 of Tobacco Hazards Prevention Act:

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

● The Allotment of the Net Revenues of Lotteries

According to Article 6 of Public Welfare Lottery Issue Act:

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

● Medical Expenditures

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

● Insurance Cost

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

3. Contracting and Management of Medical Care Institutions

● Contracted Categories of Medical Care Institutions

In accordance with Article 59 of the Enforcement Rules of the National Health Insurance Act, local community hospitals, metropolitan hospitals and academic medical centers refer to those local community hospitals, metropolitan hospitals and academic medical centers which have been evaluated and designated by hospital accreditation conducted by the competent authority. Hospitals which applied for hospital accreditation before 2010 and have been accredited as hospitals above the First Type and Second Type should be deemed as local community hospitals and metropolitan hospitals in the Act.

● Insured Beds

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

● The Proportion of Insured Beds

This is calculated in accordance to Article 33 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions.

(Total number of insured beds in contracted medical care institutions / Total number of beds in contracted medical care institutions) × 100

● The Proportion of Insured Acute Beds

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

● The Proportion of Insured Chronic Beds

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

● Corrections

In accordance with Article 36 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions, the insurer may impose one contract-violation point to the insurance medical care institutions for any of the following circumstances:

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

(2) Violation of Articles 10 to 14, Articles 16 to 17, Article 25, Paragraph 2 of Article 32, Article 33 or Article 34;

(3) Failure to audit the medical papers of insurance beneficiaries in accordance with the Regulations Governing the Medical Services Covered under National Health Insurance. Notwithstanding, the above may not apply to the case where the NHI IC card is later submitted for inspection after emergency treatment is given.

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

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

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

(7) Improper request for difference payment from a beneficiary with the difference exceeding the maximum benefit set by the insurer;

(8) In violation of Article 73 of the Act; or

(9) Failure to rectify the situation within the deadline set forth by the insurer.

● Penalties

In accordance with Article 37 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions, the insurer may deduct ten times of the reported medical expenses by the insurance medical care institutions based on the average total value of the most recent quarter of their locations should the insurance medical care institutions be found under any of the following circumstances:

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

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

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

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

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

(6) Retention of personnel who are not qualified medical personnel to conduct medical personnel' s duties other than those of physicians;

The insurer may directly deduct the medical expenses payable to the insurance medical care institutions for the abovementioned deductions.

● Suspension of Contract

(1) In accordance with Article 38 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions, the insurer shall suspend the contract for one month if the insurance medical care institution has any of the following circumstances during the term of the contract. Notwithstanding, in the case of contracted hospitals, the insurer may suspend the medical department or specific service item which violates the requirement, or the outpatient, inpatient services in whole or in part for one month in accordance with the seriousness of the violation.

i. Violation of Article 68 or Paragraph 1 of Article 80 and again after three disciplinary actions by the insurer;

ii. Violation of Article 36 and subject to the punitive measure of three contract-violation points and the same violation again;

iii. One of the subparagraphs in the preceding article after medical expenses being deducted three times;

iv. Refusal to provide appropriate medical services to insurance beneficiaries and such offense being significant.

(2) In accordance with Article 39 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions, the insurer may suspend the contract for one to three months if the contracted insurance medical care institution has any of the following circumstances during the term of the contract. Notwithstanding, in the case of contracted hospitals, the insurer may suspend the medical department or specific service item which violates the requirement, or the outpatient, inpatient services in whole or in part for one to three months in accordance with the seriousness of the violation.

i. Declaration of medical expenses incurred by non-beneficiaries in the name of beneficiaries;

ii. Provision of medications, nutrient supplements or other items not necessary for treatments to beneficiaries, registration of unnecessary medical services and declaration of medical expenses;

iii. Falsifying medical expenses by forging medical records with no diagnosis or treatment rendered;

iv. Other unscrupulous behavior or false certifications, reports or statements in order to declare medical expenses; or

v. Retention of personnel who are not qualified physicians to provide medical services for beneficiaries and declaring medical expenses by the contracted medical care institution.

● Termination of Contract

In accordance with Article 40 of the Regulations Governing Contracting and Management of NHI Medical Care Institutions, the insurer shall terminate the contract if the contracted insurance medical care institution has any of the following circumstances. Notwithstanding, in the case of contracted hospitals, the insurer may suspend the medical department or specific service item which violates the requirement, or the outpatient, inpatient services in whole or in part for one year in accordance with the seriousness of the violation.

(1) Insurance medical care institutions or their responsible medical personnel has been suspended pursuant to the preceding Article and the same offence was found within five years after the completion of such suspension;

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

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

(4) The contracted insurance medical care institution retains personnel who are not qualified physicians to provide medical services for beneficiaries and declare medical expenses, which is deemed as a serious violation.

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

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

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

4. Medical Benefits

● Number of Outpatient Cases

The number of outpatient cases was claimed by contracted medical care institutions; delivery institutions were excluded.

● Number of Inpatient Cases

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

● Medical Points

Requested Points + Copayment

● Requested Points

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

● Approved Benefit Payments / Points

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

● Copayment

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

● Inpatient Days

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

● Average Medical Points per Case

Medical Points / Number of Cases

● Average Medical Points per Day

Medical Points / Days in the Hospital

● Average Length of Stay

Days in the hospital / Number of Cases

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

(1) According to Article 55 of the National Health Insurance Act, the following may apply for reimbursement of self-advanced medical expenses from the insurer:

i. Those within the Taiwan area who avail of medical visit from non-contracted medical institutions due to emergency or childbirth;

ii. Those outside of the Taiwan area who are afflicted with special illness as determined by the insurer and requiring local medical care due to unforeseen illnesses or emergency childbirth. The reimbursement amount should not be higher than the maximum amount set by the Competent Authority;

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

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

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

(2) According to Article 56 of the National Health Insurance Act, the insured should apply for reimbursement of self-advanced medical expenses according to the preceding article in the following deadlines:

i. Insured persons under subparagraphs 1, 2, or 4 must apply for reimbursement of medical

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

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

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

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

● General Cases

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

● Case-payment Cases

This refers to the medical claims when the primary diagnosis codes or operation (treatment) codes belong to the ICD-9-CM diagnostic codes or the operation (treatment) codes under Section 6 of the National Health Insurance Medical Benefits and Reimbursement Schedule, and apply for benefits in accordance to the Schedule and relevant regulations.

● Special Cases

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

● Pilot Project

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

● Delivery Institutions

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

● Tw-DRGs Cases

Tw-DRGs Cases refer to those specified under Part VII of the National Health Insurance Medical Benefits and Reimbursement Schedule.

● Inpatient Hospice Care Cases

Inpatient hospice care cases refer to those specified under section 8, chapter 1, Part II of the National Health Insurance Medical Benefits and Reimbursement Schedule.

● Commission cases

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

● Major Illness/Injury

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

●Quarterly Floating Point Value

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

For dental institutions（before 2007）and institutions practicing western medicine, the global budget for the current quarter included the additional expenses incurred from new areas applicable to the "Separation of Prescription and Dispensing" policy.

●Quarterly Average Point Value

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

For dental institutions（before 2007）and institutions practicing western medicine, the global budget for the current quarter included additional expenses incurred from new areas applicable to the "Separation of Prescription and Dispensing" policy.

Explanatory Notes to Medical Benefits

1. Data Resources

   (1) Claims: Data Warehouse System

   (2) Payments: Medical Information System

2. Statistical Coverage: Commission cases were excluded.

3. Definition

   Medical Points= Requested points + Copayment

4. When calculating the number of cases, cases as follows are excluded:

   (1) Outpatient cases exclude cases to medical examination referrals, refillable prescriptions for patients with chronic illnesses, delivery institutions and supplementary claims. Duplicate filling cases of prescribing Hepatitis B or C medications are also excluded.

   (2) Inpatient cases exclude cases to supplementary claims. Duplicate filling cases of prescribing Hepatitis B or C medications are also excluded.