No. 1992-113

AN ACT

HB 20

Providing a comprehensive plan for health care for uninsured children; providing for medical education assistance; making appropriations; and making repeals.

TABLE OF CONTENTS

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

CHAPTER 1
GENERAL PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Children's Health Care Act.

Section 102. Legislative findings and intent.

The General Assembly finds and declares as follows:

(1) All citizens of this Commonwealth should have access to affordable and reasonably priced health care and to nondiscriminatory treatment by health insurers and providers.

(2) The uninsured health care population of this Commonwealth is estimated to be over 1,000,000 persons, and many thousands more lack adequate insurance coverage. It is also estimated that approximately two-thirds of the uninsured are employed or dependents of employed persons.

(3) Over one-third of the uninsured health care population are children. Uninsured children are of particular concern because of their need for ongoing preventative and primary care. Measures not taken to care for such children now will result in higher human and financial costs later.

(4) Uninsured children lack access to timely and appropriate primary and preventive care. As a result, health care is often delayed or foregone resulting in increased risk of developing more severe conditions which, in turn, are more expensive to treat. This tendency to delay care and to seek ambulatory care in hospital-based settings also causes inefficiencies in the health care system.

(5) Health care markets have been distorted through cost shifts for the uncompensated health care costs of uninsured citizens of this Commonwealth which has caused decreased competitive capacity on the part of those health care providers who serve the poor and increased costs of other health care payors.

(6) Although the proper implementation of spenddown provisions under medical assistance should result in the provision of the vast majority of all hospital care for the uninsured through the medical assistance program, hospitals vary widely in the application of the spenddown provision so patients can qualify for medical assistance.

(7) No one sector can absorb the cost of providing health care to citizens of this Commonwealth who cannot afford health care on their own. The cost is too large for the public sector alone to bear and instead requires the establishment of a public and private partnership to share the costs in a manner economically feasible for all interests. The magnitude of this need also requires that it be done on a time-phased, cost-managed and planned basis.

(8) Eligible children in this Commonwealth should have access to cost-effective, comprehensive primary health coverage if they are unable to afford coverage or obtain it.

(9) Care should be provided in appropriate settings by efficient providers, consistent with high quality care and at an appropriate stage, soon enough to avert the need for overly expensive treatment.

(10) Equity should be assured among health providers and payors by providing a mechanism for providers, employers, the public sector and patients to share in financing indigent children's health care.

Section 103. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Child." A person under 13 years of age, except as provided for in section 701(d).

"Children's medical assistance." Medical assistance services to children as required under Title 14 of the Social Security Act (Public Law 74-271, 42 U.S.C. § 301 et seq.), including EPSDT services.

"Council." The Children's Health Advisory Council established in section 701(i).

"Department." The Department of Public Welfare of the Commonwealth.

"EPSDT." Early and periodic screening, diagnosis and treatment.

"Fund." The Children's Health Fund for health care for indigent children established by section 1296 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971.

"Genetic status." The presence of a physical condition in an individual which is a result of an inherited trait.

"Grantee." An entity selected by the management team to receive a grant under Chapter 7. The term includes an entity, and its subsidiary, which is established under 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations); the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921; or the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Group." A group for which a health insurance policy is written in this Commonwealth.

"Health maintenance organization" or "HMO." An entity organized and regulated under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

"Health service corporation." A professional health service corporation as defined in 40 Pa.C.S. § 6302 (relating to definitions).

"Hospital." An institution having an organized medical staff which is engaged primarily in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of injured, disabled, pregnant, diseased or sick or mentally ill persons. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties. The term does not include facilities caring exclusively for the mentally ill.

"Hospital plan corporation." A hospital plan corporation as defined in 40 Pa.C.S. § 6101 (relating to definitions).

"Insurer." Any insurance company, association, reciprocal, nonprofit hospital plan corporation, nonprofit professional health service plan, health maintenance organization, fraternal benefits society or a risk-bearing PPO or nonrisk-bearing PPO not governed and regulated under the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1001 et seq.).

"MAAC." The Medical Assistance Advisory Committee.

"Managed care organization." A health maintenance organization organized and regulated under the act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act, or a risk-assuming preferred provider organization or exclusive provider organiza-

tion, organized and regulated under the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Management team." The Children's Health Insurance Management Team established in section 701(f).

"MCH." Maternal and Child Health.

"Medical assistance." The State program of medical assistance established under the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code.

"Medicaid." The Federal medical assistance program established under Title XIX of the Social Security Act (Public Law 74-271, 42 U.S.C. § 1396 et seq.).

"Mid-level health professional." A physician assistant, certified registered nurse practitioner, nurse practitioner or a certified nurse midwife.

"Parent." A natural parent, stepparent, adoptive parent, guardian or custodian of a child.

"PPO." A preferred provider organization subject to the provisions of section 630 of act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Preexisting condition." A disease or physical condition for which medical advice or treatment has been received prior to the effective date of coverage.

"Secretary." The Secretary of the Department of Health.

"Spenddown." A qualifying procedure for medical assistance set forth in 55 Pa. Code Ch. 181 (relating to income provisions for categorically needy NMP-MA and MNO-MA).

"Subgroup." An employer covered under a contract issued to a multiple employer trust or to an association.

"Terminate." Includes cancellation, nonrenewal and rescission.

"Waiting period." A period of time after the effective date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of one or more medical conditions.

"WIC." The Federal Supplemental Food Program for Women, Infants and Children.

CHAPTER 7
PRIMARY HEALTH CARE PROGRAMS

Section 701. Children's health care.

(a) Dedicated funding.—The fund shall be dedicated exclusively for distribution by the management team for free and subsidized health care services under this section.

(b) Distribution of fund.—

(1) The fund shall be used to fund health care services for children as specified in this section. The management team shall assure that the program is implemented Statewide. All grants made under this section shall be on an equitable basis, based on the number of enrolled eligible children or on eligible children anticipated to be enrolled. The management team shall use its best efforts to provide grants that ensure that eligi-

ble children across this Commonwealth have access to health care services to be provided under this act.

(2) No more than 7.5% of the grant amount may be used for administrative expenses of the grantees. If, after the first three full years of operation, any grantee presents documented evidence that administrative expenses are in excess of 7.5% of the grant, the management team may make an additional allotment of funds, not to exceed 2.5% of the grant, for future administrative expenses to the grantee to the extent that the management team finds the expenses reasonable and necessary.

(3) No less than 70% of the fund shall be used to provide the health care services provided under this act for children eligible for free care under subsection (d). When the management team determines that 70% of the fund is not needed in order to achieve maximum enrollment of children eligible for free care and promulgates a final form regulation, with proposed rulemaking omitted, this paragraph shall expire.

(4) The management team shall submit a budget request for General Fund money necessary for the operation of the council and the management team.

(5) To ensure that inpatient hospital care is provided to eligible children, each primary care physician providing primary care services shall make necessary arrangements for admission to the hospital and for necessary specialty care for a child needing the care and shall continue to care for the child as a medical assistance provider in the hospital as appropriate. When appropriate, the grantee, the enrollee and the hospital shall initiate applications for medical assistance for inpatient hospital care through spenddown. Payments made under this paragraph shall be limited to the amount by which the child's family income exceeds the Medically Needy Income Level, also known as the spenddown amount, under medical assistance. Payments made under this paragraph shall be considered reimbursement of costs under another public program of the State for medical assistance purposes as specified in section 1902(a)(17) of the Social Security Act (Public Law 74-271, 42 U.S.C. § 1396a(a)(17)).

(c) Eligibility for enrollment in programs receiving funding through fund.—

(1) Any organization or corporation receiving funds from the management team to provide coverage of health care services shall enroll, to the extent that funds are available, any child who meets all of the following:

(i) Except for newborns, has been a resident of this Commonwealth for at least 30 days prior to enrollment.

(ii) Is not covered by a health insurance plan, a self-insurance plan or a self-funded plan or is eligible for or covered by medical assistance.

(iii) Is qualified based on income under subsection (d) or (e).

(iv) Has not refused to cooperate with the grantee or the hospital as provided in subsection (b)(5).

(2) Enrollment may not be denied on the basis of a preexisting condition, nor may diagnosis or treatment for the condition be excluded based on the condition's preexistence.

(d) Free insurance.—The provision of health care insurance for eligible children shall be free to a child under six years of age whose family income is no greater than 185% of the Federal poverty level and shall be free to a child six years of age but less than the maximum program age whose family income is no greater than 100% of the Federal poverty level, where the maximum program age shall be:

(1) 13 years of age for the period ending September 30, 1993;
(2) 14 years of age for the period ending September 30, 1994;
(3) 15 years of age for the period ending September 30, 1995;
(4) 16 years of age for the period ending September 30, 1996[1]; and
(5) 17 years of age thereafter.

(e) Subsidized insurance.—

(1) The provision of health care insurance for an eligible child who is under six years of age and whose family income is greater than 185% of the Federal poverty level but no greater than 235% of the Federal poverty level may be subsidized by the fund at a rate not to exceed 50%.

(2) The difference between the pure premium of the minimum benefit package in subsection (l)(7) and the subsidy provided under this subsection shall be the amount paid by the family of the eligible child purchasing the minimum benefit package.

(3) The family of an eligible child whose family income makes the child eligible for free or subsidized care but who cannot receive care due to lack of funds in the fund may purchase coverage for the child at cost.

(f) Duties of management team.—The Children's Health Insurance Management Team, comprised of the Secretary of the Budget, the Secretary of Health and the Insurance Commissioner, is established. The management team shall:

(1) Prepare and approve a budget using the amounts collected from the fund and any other Federal or private funds designated for the fund.

(2) Execute contracts related to expanding access to health care services for eligible children as provided in this act.

(3) Promulgate regulations necessary for the implementation and administration of this chapter.

(g) Duties of Insurance Department.—The Insurance Department shall:

(1) Annually approve insurance rates requested by any grantee for the coverage of services specified in this act.

(2) Review and approve all contracts executed for the purpose of expanding access to health care services for eligible children as provided for in this chapter.

(3) Conduct monitoring and oversight by any contracts entered into.

(4) Issue an annual report to the Governor, the General Assembly and the public for each fiscal year outlining primary health services funded for the year, detailing the outreach and enrollment efforts by each grantee, and reporting by county the number of children receiving health care services from the fund, the projected number of eligible children and the number of eligible children on waiting lists for health care services.

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[1] "1966" in enrolled bill.

(h) Duties of Department of Health.—The Department of Health shall:

(1) Provide for staff for assisting the council in carrying out its duties.

(2) Coordinate and supervise the enrollment outreach activities related to the health insurance program established under this chapter.

(3) Monitor, review and evaluate the adequacy, accessibility and availability of services delivered to children who are enrolled in the health insurance program established under this chapter.

(i) Council.—The Children's Health Advisory Council is established within the Department of Health as an advisory council.

(1) The council shall consist of 12 voting members. Members provided for in subparagraphs (iv), (v), (vi), (vii) and (viii) shall be appointed by the secretary. The council shall be geographically balanced on a Statewide basis and shall include:

(i) The Secretary of Health ex officio or a designee.

(ii) The Insurance Commissioner ex officio or a designee.

(iii) The Secretary of Public Welfare ex officio or a designee.

(iv) A representative with experience in children's health from a school of public health located in this Commonwealth.

(v) A physician with experience in children's health appointed from a list of three qualified persons recommended by the Pennsylvania Medical Society.

(vi) A representative of a children's hospital or a hospital with a pediatric outpatient clinic appointed from a list of three persons submitted by the Hospital Association of Pennsylvania.

(vii) A parent of a child who receives primary health care coverage from the fund. The initial appointment shall be a parent of a child who is eligible to receive primary health care coverage from the fund.

(viii) A midlevel professional appointed from lists of names recommended by Statewide associations representing midlevel health professionals.

(ix) The chairman and the minority chairman of the Public Health and Welfare Committee of the Senate and the chairman and the minority chairman of the Health and Welfare Committee of the House of Representatives ex officio or their designees.

(2) All initial appointments to the council shall be made within 60 days of the effective date of this act, and the council shall commence operations immediately thereafter. If any specified organization should cease to exist or fail to make a recommendation within 90 days of a request to do so, the council shall specify a new equivalent organization to fulfill the responsibilities of this section.

(3) The Secretary of Health shall chair the council. The members of the council shall annually elect, by a majority vote of the members, a vice chairperson from among the members of the council.

(4) The presence of seven members shall constitute a quorum for the transacting of any business. Any act by a majority of the members present at any meeting at which there is a quorum shall be deemed to be that of the council.

(5) All meetings of the council shall be conducted pursuant to the act of July 3, 1986 (P.L.388, No.84), known as the Sunshine Act, unless otherwise provided in this section. The council shall meet at least quarterly during its first year of operation and annually thereafter and may provide for special meetings as it deems necessary. Meeting dates shall be set by a majority vote of members of the council or by call of the chairperson upon seven days' notice to all members. The council shall publish a schedule of its meetings in the Pennsylvania Bulletin. Notice shall be published at least once in each calendar quarter and shall list a schedule of meetings of the council to be held in the subsequent calendar quarter. Notice shall specify the date, time and place of the meeting and shall state that the council's meetings are open to the general public. All action taken by the council shall be taken in open public session and shall not be taken except upon a majority vote of the members present at a meeting at which a quorum is present.

(6) The members of the council shall not receive a salary or per diem allowance for serving as members of the council but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties.

(7) Terms of council members shall be as follows:

(i) The appointed members shall serve for a term of three years and shall continue to serve thereafter until their successors are appointed.

(ii) An appointed member shall not be eligible to serve more than two full consecutive terms of three years. Vacancies shall be filled in the same manner in which they were designated within 60 days of the vacancy.

(iii) An appointed member may be removed by the appointing authority for just cause and by a vote of at least seven members of the council.

(8) The council shall review and comment on the outreach plan submitted by any potential grantee as specified in section 702 and may make recommendations to the Insurance Department.

(9) In conjunction with the Department of Health, the council shall review and evaluate the accessibility and availability of services delivered to children enrolled in the program.

(j) Grant criteria.—The management team shall annually solicit applications for grants to be made pursuant to this section pursuant to the following:

(1) To the fullest extent practicable, grants shall be made to applicants that contract with providers to provide primary care services for enrollees on a cost-effective basis. The management team shall require grantees to use appropriate cost-management methods so that the fund can be used to provide the basic primary benefit services to the maximum number of eligible children and, whenever possible, to pursue and utilize available public and private funds. This shall include contracting with qualified, cost-effective providers, including hospital outpatient departments, HMO's, managed care providers, clinics, group practices and individual practitioners.

(2) To the fullest extent practicable, the management team shall ensure that any grantee who determines that a child is not eligible because the child is eligible for medical assistance provide in writing to the family of the child the telephone number of the county assistance office where the family can call to apply for medical assistance.

(k) Health service corporations and hospital plan corporations.—Within 90 days of the effective date of this act, each health service corporation and hospital plan corporation or its entities doing business in this Commonwealth shall apply to the Insurance Department for funds from the fund to carry out the purposes of this section in the area serviced by the corporation.

(l) Contracts.—Any grantee with whom the Insurance Department enters into a contract shall do the following:

(1) Ensure to the maximum extent possible that eligible children have access to primary health care physicians and nurse practitioners on an equitable Statewide basis.

(2) Contract with qualified, cost-effective providers, which may include primary health care physicians, nurse practitioners, clinics and health maintenance organizations, to provide primary and preventive health care for enrollees on a basis best calculated to manage the costs of the services, including, but not limited to, using managed health care techniques and other appropriate medical cost management methods.

(3) Ensure that the family of a child who may be eligible for medical assistance receives assistance in applying for medical assistance, including, at a minimum, written notice of the telephone number and address of the county assistance office where the family can apply for medical assistance.

(4) Maintain waiting lists of children financially eligible for benefits who have applied for benefits but who were not enrolled due to lack of funds.

(5) Strongly encourage all providers who provide primary care to eligible children to participate in medical assistance as qualified EPSDT providers and to continue to provide care to children who become ineligible for payment under the fund but who qualify for medical assistance.

(6) Report annually to the management team and the General Assembly by county and by the provider type on the number of primary care providers providing primary care to eligible children.

(7) Provide the following minimum benefit package for eligible children:

(i) Preventive care. This subparagraph includes well-child care visits in accordance with the schedule established by the American Academy of Pediatrics and the services related to those visits, including, but not limited to, immunizations, health education, tuberculosis testing and developmental screening in accordance with routine schedule of well-child visits. Care shall also include a comprehensive physical examination, including X-rays if necessary, for any child exhibiting symptoms of possible child abuse.

(ii) Diagnosis and treatment of illness or injury, including all medically necessary services related to the diagnosis and treatment of

sickness and injury and other conditions provided on an ambulatory basis, such as laboratory tests, wound dressing and casting to immobilize fractures.

(iii) Injections and medications provided at the time of the office visit or therapy; and[1] outpatient surgery performed in the office, a hospital or freestanding ambulatory service center, including anesthesia provided in conjunction with such service or during emergency medical service.

(iv) Emergency accident and emergency medical care.

(v) Prescription drugs with a copayment of $5 per prescription.

(vi) Emergency, preventive and routine dental care. This subparagraph does not include orthodontia or cosmetic surgery.

(vii) Emergency, preventive and routine vision care, including the cost of corrective lenses and frames, not to exceed two prescriptions per year.

(viii) Emergency, preventive and routine hearing care.

(ix) Inpatient hospitalization up to 90 days per year for eligible children who cannot qualify through spenddown provisions for benefits under the medical assistance program.

(x) Spenddown amount as provided for in subsection (b)(5).

(8) Each grantee shall provide an insurance identification card to each eligible child covered under a program receiving grants from the fund. The card must not specifically identify the holder as low income.

(m) Waiver.—The department may grant a waiver of the minimum benefit package of subsection (l)(7) upon demonstration by the applicant that it is providing health care services for eligible children that meet the purposes and intent of this section.

(n) Insurance rate filing request information.—The Insurance Commissioner shall make a copy of and forward to the council all relevant information and data filed by each health service corporation and hospital plan corporation doing business in this Commonwealth, or by any other grantee, as part of an insurance rate filing request for programs receiving grants under this section.

(o) Review.—After the first year of operation and periodically thereafter, the management team shall review enrollment patterns for both the free insurance program and the subsidized insurance program. The management team shall consider the relationship, if any, among enrollment, enrollment fees, income levels and family composition. Based on the results of this study and the availability of funds, the management team is authorized to adjust the maximum income ceiling for free insurance and the maximum income ceiling for subsidized insurance by regulation. In no event, however, shall the maximum income ceiling for free insurance be raised above 185% of the Federal poverty level, nor shall the maximum income ceiling for subsidized insurance be raised above 235% of the Federal poverty level. Changes in the maximum income ceiling shall be promulgated as a[2] final-form regulation with proposed rulemaking omitted in accordance with the act of June 25, 1982 (P.L.633, No.181), known as the Regulatory Review Act.

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[1] "and" omitted in enrolled bill.

[2] "a" omitted in enrolled bill.

Section 702. Outreach.

(a) Plan.—Any entity seeking funding from the fund for providing services under this chapter shall provide not less than 2.5% of the grant award in in-kind services for outreach and shall submit as part of its application to the management team an outreach plan aimed at enrolling eligible children in the program established under this chapter. The plan shall include provisions for reaching special populations, including nonwhite and non-English-speaking children and children with disabilities; for reaching different geographic areas, including rural and inner-city areas; and for assuring that special efforts are coordinated within the overall outreach activities throughout this Commonwealth.

(b) Review.—The council shall review the outreach plan and the performance of the entities receiving funding from the fund at reasonable intervals and recommend changes in the plan or in the implementation of the plan as it deems in the best interests of the children to be served. Outreach activities shall continue as long as the fund is in existence. In no instance may a grantee be required to provide in excess of 2.5% of the grant award in in-kind services for outreach.

(c) Private funding for outreach activities.—The council, in conjunction with the grantees, the Insurance Department, the Department of Education, the Department of Health and the department, shall seek funding from private foundations, Federal agencies and other funding sources for the development and implementation of the outreach plan.

Section 703. Payor of last resort.

The grantee shall not pay any claim on behalf of an enrolled child unless all other Federal, State, local or private resources available to the child or the child's family are utilized first.

CHAPTER 13
PRIMARY CARE TO MEDICALLY UNDERSERVED AREAS

Section 1301. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Agency." The Pennsylvania Higher Education Assistance Agency.

"Designated medically underserved area." Any of the following:

(1) An area designated by the Secretary of Health as a primary health care practitioner shortage area using criteria which take into account the special barriers to the provision of health care services in a rural or inner-city area.

(2) An area designated by the United States Department of Health and Human Services as a medically underserved area, a medically underserved population or a health professional shortage area.

(3) An area designated by the United States Department of Health and Human Services as a health manpower shortage area.

"Primary health care practitioner." A health care professional providing medical services in any of the following practices: family practice, osteopathic general practice, general pediatrics, obstetrics, general internal medicine and general dentistry. The term includes physician assistants, certified registered nurse practitioners, nurse practitioners and certified nurse midwives.

"Secretary." The Secretary of Health of the Commonwealth.

Section 1302. Primary health care practitioners.

(a) Establishment.—The secretary shall establish the Primary Health Care Practitioners Program within the Department of Health to increase the availability of primary health care practitioners to rural and inner-city designated medically underserved areas of this Commonwealth.

(b) Powers and duties.—The secretary shall implement a comprehensive program designed to increase the number of primary health care practitioners in rural and urban shortage areas, including, but not limited to, the following activities:

(1) Reviewing and updating on a regular basis the designated medically underserved areas.

(2) Promoting the training of primary health care practitioners and service in designated medically underserved areas.

(3) Promoting the capacity of local communities to support primary health care practitioners.

(4) Promoting the recruitment and retention of primary health care practitioners in designated medically underserved areas.

(5) Providing to the General Assembly an annual report on the activities of the Department of Health.

(6) To the extent possible, maximizing Federal, local and private funding to achieve the purposes of this chapter.

(7) Creating an advisory committee to assist in carrying out the provisions of this chapter.

(i) The advisory committee shall be comprised of the following:

(A) The secretary, who shall serve as chairperson.

(B) Two members of the Senate appointed by the President pro tempore of the Senate, one of whom shall be a member of the minority caucus.

(C) Two members of the House of Representatives appointed by the Speaker of the House of Representatives, one of whom shall be a member of the minority caucus.

(D) One representative of a rural hospital in a designated medically underserved area selected by the secretary.

(E) One representative of an urban hospital in a designated medically underserved area selected by the secretary.

(F) Two primary health care practitioners who are physicians selected by the secretary.

(G) Two primary health care practitioners who are midlevel health professionals selected by the secretary.

(ii) Legislative members shall serve so long as they remain in office. Hospital and primary health care practitioners shall serve for two-year terms. No member of the committee shall be eligible to receive assistance under this chapter.

Section 1303. Loan forgiveness for primary health care practitioners.

(a) Establishment.—The Department of Health shall, as part of the Primary Health Care Practitioners Program provided for in section 1302, establish a loan forgiveness program for primary health care practitioners serving in medically underserved designated shortage areas.

(b) Administration and purpose.—The Department of Health shall coordinate the administration of the program with the agency for providing repayment of student loans for primary health care practitioners serving in designated medically underserved areas.

(c) Repayment assistance.—The Department of Health, in coordination with the agency, may provide assistance for the repayment of a student loan for education at an institution of higher learning received by a primary health care practitioner. Repayment assistance may not be made for a loan that is in default at the time of the application or for a loan being repaid through any other loan repayment assistance program. Repayment shall be made by the agency to the lending institution on behalf of the loan recipient.

(d) Eligibility.—Consideration for loan repayment assistance shall be as follows:

(1) The applicant must be one of the following:

(i) An individual who:

(A) has a medical degree from an accredited medical school or osteopathic medical college;

(B) has completed an approved graduate training program in primary care medicine;

(C) is licensed to practice medicine in this Commonwealth; and

(D) is board eligible in a primary care specialty.

(ii) An individual who is licensed to practice general dentistry in this Commonwealth.

(iii) An individual who holds a nursing degree from an accredited nursing program and has completed a training program for nurse practitioners or nurse midwives.

(iv) An individual who has graduated from an accredited program for physician assistants.

(2) An applicant who is qualified under paragraph (1) must agree to serve in a designated medically underserved area of this Commonwealth as a primary health care practitioner for not less than three years.

(e) Benefits.—

(1) A physician or dentist who is eligible under subsection (d) shall be eligible to receive up to $64,000 in loan exonerations based on the following schedule:

(i) Year one, 15%.

(ii) Year two, 20%.

(iii) Year three, 30%.
(iv) Year four, 35%.

(2) A nurse practitioner, physician assistant or nurse midwife who is eligible under subsection (d) shall be eligible to receive up to $40,000 in loan exonerations based on the following repayment schedule:

(i) Year one, 15%.
(ii) Year two, 20%.
(iii) Year three, 30%.
(iv) Year four, 35%.

(f) Contracts.—A recipient of loan repayment assistance shall enter into a contract with the agency and the Department of Health, which shall be considered a contract with the Commonwealth. Priority shall be given to those applicants who agree to engage in primary health care practice a minimum of three years or more in a designated medically underserved area. Preference shall be given to residents of this Commonwealth, minority applicants and graduates of Pennsylvania institutions providing primary health care education. The contract shall include, but not be limited to, the following terms and conditions:

(1) An unlicensed applicant shall apply for a license to practice in this Commonwealth at the earliest practicable opportunity.

(2) Within six months after licensure and the completion of all requirements for the primary care specialty, an applicant shall engage in the practice of primary health care medicine in a designated medically underserved area approved by the Department of Health. The Department of Health shall provide applicants with a list of available designated medically underserved area sites and shall, to the extent possible, approve applicant selections in the order they are received.

(3) The applicant shall agree to serve not less than three full years in a designated medically underserved area at a repayment assistance schedule as provided in subsection (e).

(4) The primary health care practitioner shall agree to treat patients in the area eligible for medical assistance and Medicare.

(5) The primary health care practitioner shall agree to practice on a full-time basis in the designated medically underserved area.

(6) The primary health care practitioner shall permit the agency or the Department of Health to monitor the practice to determine compliance with the terms of the contract.

(7) The agency shall certify compliance with the terms of the contract for purposes of receipt by the primary health care practitioner of loan repayment awards for years subsequent to the initial year of the loan.

(8) The contract shall be renewable on an annual basis upon certification by the agency that the primary health care practitioner has complied with the terms of the contract.

(9) Upon the recipient's death or total or permanent disability, the agency shall nullify the service obligation of the recipient.

(10) If the recipient is convicted of, or pleads guilty or no contest to, a felony or misdemeanor or if the appropriate licensing board has deter-

mined that the recipient has committed an act of gross negligence in the performance of service obligations or has suspended or revoked the license to practice, the agency shall have the authority to terminate the recipient's service in the program and demand repayment of the assistance rendered to date.

(11) Loan recipients who fail to begin or complete the obligations contracted for shall pay to the agency three times the amount of assistance received. Falsification or misrepresentation on an application or in verification of service shall be construed to be a default. Determination as to the time of breach of contract shall be made by the agency. Both the recipient and the agency shall make every effort to resolve conflicts in order to prevent a breach of contract.

(g) *Contract enforcement.*—The agency shall have the authority to seek garnishment of wages for the collection of damages provided for in subsection (f)(11).

Section 1304. Primary health care grants program.

The Department of Health shall, as part of the Primary Health Care Practitioners Program provided for in this chapter, establish a program for awarding demonstration grants to promote the training, recruitment and retention of primary health care practitioners in designated medically underserved areas and to promote innovative methods for delivery of primary medical services in rural designated medically underserved areas. The purpose of these grants may include, but need not be limited to, the following:

(1) Promoting health care professions to high school students.

(2) Encouraging local communities in designated medically underserved areas to support primary health care practitioners.

(3) Promoting specific programs for the education, recruitment and retention of family practitioners, particularly in designated medically underserved areas.

Such programs may include challenge grants to medical schools to promote medical education opportunities for primary health care professionals and assistance to communities to establish clinics, including mobile health clinics. In establishing priorities, the department shall give preference to programs which promote coordination of existing resources, particularly in rural areas.

CHAPTER 31
MISCELLANEOUS PROVISIONS

Section 3101. Limitation on expenditure of funds.

In no case shall the total amount of annual grant awards authorized in Chapter 7 exceed the amount of cigarette tax receipts annually deposited into the fund pursuant to section 1296 of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971, and any other Federal or private funds received through the fund. The provision of children's health care through the fund shall in no way constitute an entitlement derived from the Commonwealth or a claim on any other funds of the Commonwealth.

Section 3102. Severability.

The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.

Section 3103. Repeals.

All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 3104. Expiration.

Chapter 7 shall expire December 31, 1997.

Section 3105. Appropriations.

(a) Primary health care programs.—The sum of $50,000 is hereby appropriated from the General Fund to the Children's Health Insurance Management Team for the fiscal year July 1, 1992, to June 30, 1993, to carry out the provisions of Chapter 7 of this act.

(b) Primary care to medically underserved areas.—The sum of $1,250,000 is hereby appropriated from the General Fund for the fiscal year July 1, 1992, to June 30, 1993, to carry out the provisions of Chapter 13 of this act.

Section 3106. Effective date.

This act shall take effect as follows:

(1) Chapter 13 of this act shall take effect in 90 days.

(2) The remainder of this act shall take effect immediately.

APPROVED—The 2nd day of December, A. D. 1992.

ROBERT P. CASEY