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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1 Session of 2009

INTRODUCED BY EACHUS, DeLUCA, DeWEESE, BISHOP, BRIGGS, CALTAGIRONE, DALEY, DONATUCCI, FRANKEL, GIBBONS, GRUCELLA, HARHAI, HOUGHTON, MARKOSEK, McGEEHAN, McILVAINE SMITH, MELIO, READSHAW, SANTARSIERO, SEIP, SIPTROTH, SOLOBAY AND STABACK, MAY 21, 2009

REFERRED TO COMMITTEE ON INSURANCE, MAY 21, 2009

AN ACT

Establishing the Expanded Adult Basic Coverage Insurance Program; making appropriations; and making related repeals.

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

CHAPTER 1

PRELIMINARY PROVISIONS

Section 101. Short title.

This act shall be known and may be cited as the Expanded Adult Basic Coverage Insurance Program Act.

Section 102. 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:

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

CHAPTER 3

PENNSYLVANIA EXPANDED ADULT BASIC COVERAGE INSURANCE PROGRAM

Section 301. Scope of chapter.

This chapter relates to offering health care coverage to eligible adults.

Section 302. 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:

"Behavioral health services." Mental health or substance abuse services.

"Benefit package." Insurance coverage which provides the benefits set forth under section 303(h) for eligible adults.

"Children's Health Insurance Program." The Children's Health Care Program established under Article XXIII of the act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

"Chronic care and disease management." A model of health care that manages chronic diseases in accordance with evidence-based treatment guidelines and includes all of the following:

(1) Planned, regular interactions with caregivers to systematically assess the patient's condition and guide patient self-care to prevent exacerbation and complications of the chronic illness.

(2) Support for the patient's role as self-manager through education and continuing follow-up initiated by the health care practice.

(3) Use of information systems to organize care and monitor patient progress.

"Contractor." An insurer or other entity or its subsidiaries awarded a contract to provide health care services under this chapter.

"Eligible adult." A low-income adult who meets all of the following:

(1) Legally resides within the United States.

(2) Is a resident of this Commonwealth at the time of

application to the program.

(3) Is not currently covered by a health insurance plan, a self-insurance plan or a self-funded plan.

(4) Has not been covered by a health insurance plan, a self-insurance plan or a self-funded plan during the six months immediately preceding the determination of eligibility, except if one of the following apply:

(i) The low-income adult is eligible to receive benefits under the act of December 5, 1936 (2nd Sp.Sess., 1937 P.L.2897, No.1), known as the Unemployment Compensation Law.

(ii) The low-income adult was covered under a health insurance plan, a self-insurance plan or a self-funded plan, but, at the time of application for coverage, is no longer employed and is ineligible to receive benefits under the Unemployment Compensation Law.

(iii) The low-income adult lost coverage as a result of divorce or separation from a covered individual or the death of a covered individual.

(iv) The low-income adult lost coverage as a result of a change in employment status of a covered individual resulting in either of the exceptions set forth under subparagraph (i) or (ii) and both the eligible adult and the spouse are low-income adults and applying for coverage.

(v) The low-income adult is transferring from another government-subsidized health insurance program, including a transfer that occurs as a result of failure to meet income eligibility requirements.

(5) The low-income adult is ineligible to receive

continuous eligibility coverage under Title XIX or XXI of the Social Security Act (49 Stat. 620, 42 U.S.C. § 301 et seq.), except for benefits authorized under a waiver granted by the United States Department of Health and Human Services to implement the program.

(6) The low-income adult is ineligible for Medicare.

"Enrollee." An eligible adult who meets all the requirements of this chapter and is enrolled in the Pennsylvania Expanded Adult Basic Coverage Insurance Program.

"Health benefit plan." An insurance coverage plan that provides the benefits set forth under section 303(h). The term shall not include any of the following:

(1) An accident-only policy.

(2) A credit-only policy.

(3) A long-term care or disability income policy.

(4) A specified-disease policy.

(5) A Medicare supplement policy.

(6) A Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement policy.

(7) A fixed-indemnity policy.

(8) A dental-only policy.

(9) A vision-only policy.

(10) A workers' compensation policy.

(11) An automobile medical payment policy under 75 Pa.C.S. (relating to vehicles).

(12) Other similar policies providing for limited benefits.

"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.

"Hospital." A hospital as defined and licensed under the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act.

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

"Insurer." A company or health insurance entity licensed in this Commonwealth to issue any individual or group health, sickness or accident policy or subscriber contract or certificate or plan that provides medical or health care coverage by a health care facility or licensed health care provider that is offered or governed under any of the following:

(1) The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921.

(2) The act of December 29, 1972 (P.L.1701, No.364), known as the Health Maintenance Organization Act.

(3) The act of May 18, 1976 (P.L.123, No.54), known as the Individual Accident and Sickness Insurance Minimum Standards Act.

(4) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Low-income adult." An individual who is at least 19 years of age but less than 65 years of age and whose household income is less than 200% of the Federal poverty level at the time of eligibility determination.

"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.

"Medicare." The Federal program established under Title

XVIII of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1395 et seq.).

"Offeror." An insurer that submits a bid or proposal in response to a solicitation issued under section 303(h).

"Pre-existing condition." A disease or physical condition for which medical advice, diagnosis, care or treatment was recommended or received prior to the effective date of coverage.

"Premium assistance program." A component of the Pennsylvania Expanded Adult Basic Coverage Insurance Program, approved under a State plan or approved waiver, under which the Commonwealth pays part or all of the premium for an enrollee's group health insurance or coverage under a group health plan.

"Prescription drug." A controlled substance, other drug or device for medication dispensed by order of an appropriately licensed medical professional.

"Professional health services plan corporation." A not-for-profit corporation operating under the provisions of 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations).

"Program." The Pennsylvania Expanded Adult Basic Coverage Insurance Program.

"Unemployment Compensation Law." The act of December 5, 1936 (1937 2nd Sp.Sess., P.L.2897, No.1), known as the Unemployment Compensation Law.

"Wait-list enrollee." An eligible adult who meets all the requirements of this chapter who is not enrolled in the program due to insufficient appropriations, but who individually purchases the benefit package.

Section 303. Pennsylvania Expanded Adult Basic Coverage Insurance Program.

(a) Program establishment.--There is established in the department the Pennsylvania Expanded Adult Basic Coverage Insurance Program. The program is contingent on, and shall not be authorized without, sufficient Federal financial participation to fund the program. Appropriations to the department for the program shall be used for contracts to provide basic health care insurance for eligible adults and administration of outreach activities and for program operating costs. The department shall, to the greatest extent practicable, ensure that all eligible adults in this Commonwealth have access to the program established in this section.

(b) Eligible adult responsibilities.--An eligible adult seeking to purchase coverage under the program shall:

(1) Submit an application to the department or a contractor.

(2) Pay to the department, or the contractor with whom the eligible adult is to be enrolled, the amount of the premium specified under this subsection. Except to the extent that changes may be necessary to meet Federal requirements under section 310, subsidies for the 2009-2010 fiscal year shall result in the following premium amount based on household income for a health benefit plan:

(i) For an enrollee whose household income is not greater than 150% of the Federal poverty level, a monthly premium of $0.

(ii) For an enrollee whose household income is greater than 150% but not greater than 175% of the Federal poverty level, a monthly premium of $40.

(iii) For an enrollee whose household income is greater than 175% but not greater than 200% of the

Federal poverty level, a monthly premium of $50.

(3) Be responsible for any required copayments for health care services rendered under the benefit package in subsection (h).

(4) Notify the department or the contractor with whom the eligible adult is enrolled of any change in the eligible adult's household income.

(c) Purchase of insurance.--An eligible adult's payment to the department or the contractor with whom the eligible adult is enrolled under subsection (b)(2) shall be used to purchase the benefit package and shall be remitted so that it is received by the department or the contractor before the first day of the month for which coverage is provided. A grace period for remittance shall be permitted as provided by Federal or State law.

(d) Premium assistance program.--The department shall implement a premium assistance program permitted under Federal regulations and as permitted through a Federal waiver or State plan amendment made under this chapter. Notwithstanding any other law to the contrary, in the event that it is more cost-effective to purchase health care from an enrollee's employer-based program and the employer-based program provides, at a minimum, the benefits package described in subsection (h)(8), employer-based coverage may be purchased in place of enrollment in the program established under this chapter. An insurer shall honor a request for enrollment and purchase of employee group health insurance requested on behalf of an enrollee.

(e) Waiting list.—-The department shall maintain a waiting list of eligible adults who have applied for coverage under the program but who are not enrolled due to insufficient

appropriations. An eligible adult on the waiting list may purchase the benefit package at the monthly per-member premium cost negotiated by the department. The department shall create a procedure to remove eligible adults from the waiting list and enroll them in the program based upon available funding.

(f) Entitlements and claims.--Nothing in this chapter shall constitute an entitlement derived from the Commonwealth or a claim on any funds of the Commonwealth. The Department of Public Welfare, in conjunction with the department, shall seek approval of State plan amendments and revisions to Federal waivers as are necessary to ensure that expenditures in the program shall not exceed available funding.

(g) Department responsibilities.--The department shall work in consultation and cooperation with other appropriate Commonwealth agencies, including the Department of Public Welfare, to carry out the functions of this chapter and shall:

(1) Administer the program on a Statewide basis.

(2) Enter into contracts for health care insurance for the benefit package. Contracts may be awarded on a multiple-award basis.

(3) (i) In order to effectuate the program promptly upon receipt of all applicable waivers and approvals from the Federal government, contracts as currently exist under the Adult Basic Program or the Physical Health Health Choices Program of the Department of Public Welfare may be amended to provide benefits under the program established in this section or may otherwise procure services outside the competitive procurement process.

(ii) This paragraph shall expire at the same time as

the contracts awarded under this section, but not later than 18 months after the effective date of this section.

(4) Subject to Federal requirements, impose reasonable cost-sharing arrangements establishing and adjusting copayments to be incorporated into the program by contractors, thereby encouraging appropriate use by contractors of cost-effective health care providers who will provide quality health care. Changes to copayments shall be forwarded to the Legislative Reference Bureau for publication as notices in the Pennsylvania Bulletin.

(5) Conduct monitoring, oversight and audits of executed contracts for enforcement purposes.

(6) Ensure that the eligibility of enrollees receiving subsidization of the benefit package is redetermined on an annual basis.

(7) Monitor, review and evaluate each contractor's benefit package for the adequacy, accessibility and availability of the services required under subsection (h).

(8) Establish and coordinate development, implementation and supervision of an outreach plan to ensure that all those who may be eligible are aware of the program. The outreach plan shall include provisions for:

(i) Reaching special populations, including nonwhite and non-English speaking individuals and individuals with disabilities.

(ii) Reaching different geographic areas, including rural and inner-city areas.

(iii) Assuring that special efforts are coordinated within the overall outreach activities throughout this Commonwealth.

(iv) Allowing for the acceptance of applications at county assistance offices operated by the Department of Public Welfare.

(9) Prepare and submit, by March 1, 2010, and annually thereafter, a report to the chairman and minority chairman of the Banking and Insurance Committee of the Senate and to the chairman and minority chairman of the Insurance Committee of the House of Representatives regarding the number of eligible adults purchasing coverage under the program with a geographic distribution, the identity of the contractors, the scope of the services being provided, the level of outreach, the cost of the insurance and the amount an eligible adult contributes toward the insurance, including any copayments and adjustments to the premiums. The annual report shall be made available for public inspection and posted on the department's publicly accessible Internet website.

(10) Undertake efforts as are required to seek receipt of and qualify for Federal financial participation.

(h) Solicitation.--The department shall solicit bids or proposals for the program. The solicitation shall require an offeror to assure that if selected as a contractor it will do all of the following:

(1) Ensure that enrollees and wait-list enrollees have access to qualified, cost-effective health care providers.

(2) Contract with qualified, cost-effective health care providers, which shall include primary health care physicians, certified registered nurse practitioners, physician assistants, clinical nurse specialists, nurse-midwives, clinics and health maintenance organizations, to provide health care for organizations, to provide health care

for enrollees and wait-list enrollees in a manner that best manages the costs of the services and utilizes other appropriate medical cost-effective methods and in a manner consistent with the provider's permitted scope of practice.

(3) Ensure that the individual applying for coverage is an eligible adult. If a review of the individual's application for coverage indicates that the individual is not eligible for adult basic coverage insurance, but may be eligible for medical assistance, the application for benefits and all accompanying documentation shall be promptly transmitted to the appropriate county assistance office for a determination of eligibility for medical assistance or other Federal, State and local resources available to the individual.

(4) Not prohibit enrollment based upon a preexisting condition nor exclude a diagnosis or treatment for the condition based on the condition's preexistence.

(5) Provide an insurance identification card to each enrollee or wait-list enrollee covered under a contract executed under this section. The card shall not identify the enrollee or wait-list enrollee as low income.

(6) Require each provider providing primary care services under this section to make necessary arrangements for admission to hospitals and for necessary specialty care.

(7) Not pay any claim on behalf of an enrollee or wait-list enrollee unless all other Federal, State and local resources are first utilized and utilize subrogation and coordination of benefits processes so that the program is the payor of last resort.

(8) Provide a benefit package to enrollees and wait-list

enrollees consistent with the scope and duration requirements determined by the department. The Commonwealth may elect to provide any benefit independently and outside the scope of any contract entered into with any contractor to provide the benefit package under the program. The benefit package determined by the department may include any of the following services:

(i) Preventive and wellness care.

(ii) Outpatient primary care and specialist services.

(iii) Inpatient hospitalization.

(iv) Outpatient services.

(v) Emergency care.

(vi) Laboratory and radiology.

(vii) Clinic services.

(viii) Prescription drugs.

(ix) Diabetic medical supplies and equipment.

(x) Emergency dental care.

(xi) Maternity care.

(xii) Skilled nursing.

(xiii) Home health, palliative and hospice care.

(xiv) Chronic care and disease management.

(xv) Inpatient and outpatient behavioral health services.

(i) Bids or proposals.--Each professional health service plan corporation, hospital plan corporation, health maintenance organization owned or controlled by a professional health service plan corporation or a hospital plan corporation and each entity that provides services under the Department of Public Welfare's Physical Health HealthChoices Program shall be

required to submit a bid or proposal to the department to carry out the purposes of this chapter. Each professional health service plan corporation and hospital plan corporation, and subsidiaries and affiliates doing business in this Commonwealth, shall submit a bid or proposal to the department to carry out the purposes of this section in the geographic area serviced by that entity. Each health maintenance organization owned or controlled by a health service plan corporation or hospital plan corporation shall submit a bid or proposal with all eligible licenses and certificates of authority under its control, in all service zones in which it is licensed to do business in more than 50% of the counties in that zone. The service zones shall be determined by the department in consultation with the Department of Health and the Department of Public Welfare. Each entity that provides services under the Physical Health HealthChoices Program of the Department of Public Welfare shall submit a bid or proposal in all counties in which it provides the services. All other insurers may submit a bid or proposal to the department to carry out the purposes of this section.

(j) Reviewing, scoring and selecting bids or proposals.--The department, in consultation with the Department of Public Welfare, shall review and score bids or proposals on the basis of all of the requirements for the program. The department may include other criteria in the solicitation and in the scoring and selection of the bids or proposals that the department, in the exercise of its administrative duties under this section and in consultation with the Department of Public Welfare, deems necessary. The department shall:

(1) Select, to the greatest extent practicable, offerors that contract with providers to provide health care services

on a cost-effective basis and that use appropriate cost-management methods that enable the program to provide coverage to the maximum number of eligible adults and that, whenever possible, pursue and utilize available public and private funds.

(2) Select, to the greatest extent practicable, only offerors that comply with all procedures relating to coordination of benefits as required by the department and the Department of Public Welfare.

(3) Select offerors that limit administrative expenses to no more than 10% of the amount of the contract. If a contractor presents documented evidence that administrative expenses for operational changes from the previous AdultBasic Program to the program implemented under this act are in excess of 10% of the amount of the contract, the department shall make an additional allotment of funds, not to exceed 1% of the amount of the contract, to the contractor to the extent that the department finds the expenses reasonable and necessary.

(k) Rates and negotiations.--Rates for the program shall be approved annually by the department and may vary by region and contractor. Rates shall be based on an actuarially sound and adequate review. The department shall not negotiate a contract for a period in excess of four years.

(l) Limitation.--In no case shall the total aggregate amount of annual contracts entered into pursuant to this section exceed the amount of the aggregate annual appropriations to the department for the program.

Section 304. Duties of contractors.

A contractor that contracts with the department to provide a

health benefit plan to eligible adults:

(1) Shall process claims for the coverage.

(2) Shall implement copayment adjustments as soon as practicable following publication in the Pennsylvania Bulletin, but in no event more than 120 days following publication.

(3) May not deny coverage to an eligible adult who has been approved by the department to participate in the program.

(4) Shall provide to the department all data, including individual claims data, as the department determines is necessary for use in performance measurement and program improvement.

(5) Shall fulfill all requirements of any contract issued to it pursuant to this section.

Section 305. Premiums and charges.

(a) Limitation on fees.--No eligible adult shall be assessed a fee or other charge, other than those specified in this chapter, as a requirement for participating in the program.

(b) Premium adjustment.--For each fiscal year beginning after June 30, 2010, the department may adjust the premium amounts under section 303(b)(2) to reflect changes in the cost of medical services and shall forward notice of the new premium amounts to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(c) Copayment adjustment.--For each fiscal year beginning after June 30, 2010, the department may adjust the copayment amounts under section 303(b)(3) to reflect changes in the cost of medical services and shall forward notice of the new premium amounts to the Legislative Reference Bureau for publication as a

notice in the Pennsylvania Bulletin.

Section 306. Data matching.

(a) Covered adults.--All entities providing health insurance or health care coverage within this Commonwealth shall, at least once every month, provide the names, identifying information and any additional information on coverage and benefits as the department may specify for persons for whom the entities provide insurance or coverage.

(b) Use of information.--The department shall use the information obtained under subsection (a) to determine whether another entity has primary liability for health care claims paid by the program. If a determination is made that the enrollee or wait-list enrollee has other health care coverage, the eligibility of the enrollee or wait-list enrollee shall be reevaluated, as shall the most cost-effective means of providing coverage for that enrollee or wait-list enrollee.

Section 307. Information sharing.

Notwithstanding any provision of law to the contrary, the program and other departments or programs of the Commonwealth with information relating to the eligibility of individuals for a Commonwealth program, shall share the information with each other for purposes of determining and coordinating eligibility for any State program. Those departments and programs include, but are not limited to, the Department of Revenue, the Department of Labor and Industry, the Department of Public Welfare, the Children's Health Insurance Program and the program. The information shall be confidential, shall be exempt from disclosure under the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law, and may not be subject to subpoena and may not be made public by any department or

program, except that it may be disclosed to another Commonwealth agency or law enforcement official of the Federal or State government at any time so long as the agency or office receiving the information agrees in writing to hold it confidential and in a manner consistent with this act. No individual who receives information while acting under the authority of this act shall be permitted or required to testify in a private civil or other action concerning the information subject to this section.

Section 308. Regulations.

The department may promulgate regulations for the implementation and administration of the program. Until final regulations are adopted, the department shall operate the program under interim guidelines consistent with this chapter.

Section 309. Funding.

(a) Funding contingency for subsidization.--Subsidization of premiums and copayments paid under subsection (b) is contingent upon the amount of the funding available to the program and the Federal poverty levels approved by the Federal waiver or State plan amendments granted under section 310, and is limited to eligible adults who are in compliance with the requirements under this chapter.

(b) Use of funding.--Funding shall be used by the department to pay the difference between the total monthly cost of the health benefit plan and the premium payments and copayments by the eligible adult and for administration and outreach activities required under subsection 303(f).

Section 310. Federal waivers or State plan amendments.

(a) Application for waivers or amendments.--The Department of Public Welfare, in cooperation with the department, shall apply for all applicable waivers from the Federal Government and

shall seek approval to amend the State plan under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) as necessary to carry out the provisions of this chapter.

(b) Notice of approval.--If the Department of Public Welfare receives approval of a waiver or approval of a State plan amendment, it shall notify the department and shall transmit notice of the waiver or State plan amendment approvals to the Legislative Reference Bureau for publication as a notice in the Pennsylvania Bulletin.

(c) Program changes.--The department is authorized to change the benefits under section 303(h), the premium amounts payable under section 303(b) and any eligibility requirements under this chapter in order for the program to meet Federal requirements.

Section 311. Federal funds.

Notwithstanding any other provision of law, the Department of Public Welfare, in cooperation with the department, shall do all of the following:

(1) Seek the receipt of Federal financial participation under Title XIX of the Social Security Act (49 Stat. 620, 42 U.S.C. § 1396 et seq.) for coverage and services provided under this article.

(2) Qualify for available Federal financial participation under Title XIX of the Social Security Act.

Section 312. Federal programs.

If the Federal Government enacts programs similar to the program, the program shall be construed to only supplement the Federal programs; and adults qualified for coverage under the Federal program shall utilize that Federal program before utilizing the program.

Section 313. Establishment.

There is established within the State Treasury a special fund to be known as the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund.

Section 314. Deposits into fund and appropriation.

(a) Health Care Provider Retention Account.--On the effective date of this section, the sum of $362,000,000 shall be transferred from the Health Care Provider Retention Account to the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund.

(b) Tobacco Settlement Act.--Notwithstanding section 5101(b), funds appropriated under section 306(b)(1)(vi) of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act, for the program established in former Chapter 13 of that act, shall be deposited into the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund.

(c) Premium tax.--Commencing with calendar years beginning after December 31, 2010, every hospital plan corporation and professional health service plan corporation operating in this Commonwealth shall pay the tax on gross premiums payable under Article IX of the act of March 4, 1971 (P.L.6, No.2), known as the Tax Reform Code of 1971. The tax payable in calendar year 2011 shall be for gross premiums received in calendar year 2010. Notwithstanding the provisions of any law to the contrary, the sums received by the Commonwealth as a result of this tax shall be deposited into the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund. This subsection shall not be effective if the Agreement on Community Health Reinvestment entered into February 2, 2005, by the department and Capital BlueCross, Highmark, Inc., Hospital Service Association of Northeastern Pennsylvania and Independence Blue Cross and published in the

Pennsylvania Bulletin at 35 Pa.B. 4155 (July 23, 2005) is extended or otherwise renegotiated to continue, at least, at the level of Annual Community Health Reinvestment contributed under that agreement. In that event, the sums received by the Commonwealth shall be deposited into the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund.

(d) Appropriation.--Money in the Pennsylvania Expanded Adult Basic Coverage Insurance Program Fund is appropriated, upon approval of the Governor, for health care coverage and services under this chapter.

CHAPTER 51

MISCELLANEOUS PROVISIONS

Section 5101. Repeals.

(a) Declaration of policy.--The General Assembly declares that the repeal under subsection (b) is necessary to effectuate this act.

(b) Specific.--Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the Tobacco Settlement Act, is repealed.

(c) Inconsistent.--All acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 5102. Effective date.

This act shall take effect in 90 days.