Rep. Elaine Nekritz

Filed: 5/31/2008

AMENDMENT TO SENATE BILL 101

AMENDMENT NO. _____. Amend Senate Bill 101, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, ~~and~~ 356z.9, 356z.10, and 356z.11 ~~and 356z.9~~ of the Illinois Insurance Code. The

program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 10. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, 356z.10, and 356z.11 ~~and 356z.9~~ of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 15. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, 356z.10, and 356z.11 ~~and 356z.9~~ of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.
(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 20. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance

protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, and 356z.11 of the Illinois Insurance Code. (Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; revised 12-4-07.)

Section 25. The Illinois Insurance Code is amended by adding Sections 356z.11 and 370c as follows:

(215 ILCS 5/356z.11 new)

Sec. 356z.11. Habilitative services for children.

(a) As used in this Section, "habilitative services" means occupational therapy, physical therapy, speech therapy, and other services prescribed by the insured's treating physician pursuant to a treatment plan to enhance the ability of a child to function with a congenital, genetic, or early acquired disorder. A congenital or genetic disorder includes, but is not limited to, hereditary disorders. An early acquired disorder refers to a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking, or self-help skills. Congenital, genetic, and early acquired disorders may include, but are not limited to, autism or an autism spectrum disorder, cerebral

palsy, and other disorders resulting from early childhood illness, trauma, or injury.

(b) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide coverage for habilitative services for children under 19 years of age with a congenital, genetic, or early acquired disorder so long as all of the following conditions are met:

(1) A physician licensed to practice medicine in all its branches has diagnosed the child's congenital, genetic, or early acquired disorder.

(2) The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, licensed physician, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist upon the referral of a physician licensed to practice medicine in all its branches.

(3) The initial or continued treatment must be medically necessary and therapeutic and not experimental or investigational.

(c) The coverage required by this Section shall be subject to other general exclusions and limitations of the policy, including coordination of benefits, participating provider

requirements, restrictions on services provided by family or household members, utilization review of health care services, including review of medical necessity, case management, experimental, and investigational treatments, and other managed care provisions.

(d) Coverage under this Section does not apply to those services that are solely educational in nature or otherwise paid under State or federal law for purely educational services. Nothing in this subsection (d) relieves an insurer or similar third party from an otherwise valid obligation to provide or to pay for services provided to a child with a disability.

(e) Coverage under this Section for children under age 19 shall not apply to treatment of mental or emotional disorders or illnesses as covered under Section 370 of this Code as well as any other benefit based upon a specific diagnosis that may be otherwise required by law.

(f) The provisions of this Section do not apply to short-term travel, accident-only, limited, or specific disease policies.

(g) Any denial of care for habilitative services shall be subject to appeal and external independent review procedures as provided by Section 45 of the Managed Care Reform and Patient Rights Act.

(h) Upon request of the reimbursing insurer, the provider under whose supervision the habilitative services are being

provided shall furnish medical records, clinical notes, or other necessary data to allow the insurer to substantiate that initial or continued medical treatment is medically necessary and that the patient's condition is clinically improving. When the treating provider anticipates that continued treatment is or will be required to permit the patient to achieve demonstrable progress, the insurer may request that the provider furnish a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

(i) The Department may not adopt rules to amend the provisions of the amendatory Act of the 95th General Assembly.

(215 ILCS 5/370c) (from Ch. 73, par. 982c)

Sec. 370c. Mental and emotional disorders.

(a) (1) On and after the effective date of this Section, every insurer which delivers, issues for delivery or renews or modifies group A&H policies providing coverage for hospital or medical treatment or services for illness on an expense-incurred basis shall offer to the applicant or group policyholder subject to the insurers standards of insurability, coverage for reasonable and necessary treatment and services for mental, emotional or nervous disorders or conditions, other than serious mental illnesses as defined in item (2) of subsection (b), up to the limits provided in the

policy for other disorders or conditions, except (i) the insured may be required to pay up to 50% of expenses incurred as a result of the treatment or services, and (ii) the annual benefit limit may be limited to the lesser of $10,000 or 25% of the lifetime policy limit.

(2) Each insured that is covered for mental, emotional or nervous disorders or conditions shall be free to select the physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor of his choice to treat such disorders, and the insurer shall pay the covered charges of such physician licensed to practice medicine in all its branches, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor up to the limits of coverage, provided (i) the disorder or condition treated is covered by the policy, and (ii) the physician, licensed psychologist, licensed clinical social worker, or licensed clinical professional counselor is authorized to provide said services under the statutes of this State and in accordance with accepted principles of his profession.

(3) Insofar as this Section applies solely to licensed clinical social workers and licensed clinical professional counselors, those persons who may provide services to individuals shall do so after the licensed clinical social worker or licensed clinical professional counselor has

informed the patient of the desirability of the patient conferring with the patient's primary care physician and the licensed clinical social worker or licensed clinical professional counselor has provided written notification to the patient's primary care physician, if any, that services are being provided to the patient. That notification may, however, be waived by the patient on a written form. Those forms shall be retained by the licensed clinical social worker or licensed clinical professional counselor for a period of not less than 5 years.

(b) (1) An insurer that provides coverage for hospital or medical expenses under a group policy of accident and health insurance or health care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 92nd General Assembly shall provide coverage under the policy for treatment of serious mental illness under the same terms and conditions as coverage for hospital or medical expenses related to other illnesses and diseases. The coverage required under this Section must provide for same durational limits, amount limits, deductibles, and co-insurance requirements for serious mental illness as are provided for other illnesses and diseases. This subsection does not apply to coverage provided to employees by employers who have 50 or fewer employees.

(2) "Serious mental illness" means the following psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the

American Psychiatric Association:

(A) schizophrenia;

(B) paranoid and other psychotic disorders;

(C) bipolar disorders (hypomanic, manic, depressive, and mixed);

(D) major depressive disorders (single episode or recurrent);

(E) schizoaffective disorders (bipolar or depressive);

(F) pervasive developmental disorders;

(G) obsessive-compulsive disorders;

(H) depression in childhood and adolescence;

(I) panic disorder; and

(J) post-traumatic stress disorders (acute, chronic, or with delayed onset).

(3) Upon request of the reimbursing insurer, a provider of treatment of serious mental illness shall furnish medical records or other necessary data that substantiate that initial or continued treatment is at all times medically necessary. An insurer shall provide a mechanism for the timely review by a provider holding the same license and practicing in the same specialty as the patient's provider, who is unaffiliated with the insurer, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself or herself), the patient's provider, and the insurer in the event of a dispute between the insurer and patient's provider regarding the medical necessity of a

treatment proposed by a patient's provider. If the reviewing provider determines the treatment to be medically necessary, the insurer shall provide reimbursement for the treatment. Future contractual or employment actions by the insurer regarding the patient's provider may not be based on the provider's participation in this procedure. Nothing prevents the insured from agreeing in writing to continue treatment at his or her expense. When making a determination of the medical necessity for a treatment modality for serous mental illness, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process.

(4) A group health benefit plan:

(A) shall provide coverage based upon medical necessity for the following treatment of mental illness in each calendar year:

(i) 45 days of inpatient treatment; and

(ii) beginning on June 26, 2006 (the effective date of Public Act 94-921), 60 visits for outpatient treatment including group and individual outpatient treatment; and

(iii) for plans or policies delivered, issued for delivery, renewed, or modified after January 1, 2007 (the effective date of Public Act 94-906), 20 additional outpatient visits for speech therapy for

treatment of pervasive developmental disorders that will be in addition to speech therapy provided pursuant to item (ii) of this subparagraph (A);

(B) may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and

(C) shall include the same amount limits, deductibles, copayments, and coinsurance factors for serious mental illness as for physical illness.

(5) An issuer of a group health benefit plan may not count toward the number of outpatient visits required to be covered under this Section an outpatient visit for the purpose of medication management and shall cover the outpatient visits under the same terms and conditions as it covers outpatient visits for the treatment of physical illness.

(6) An issuer of a group health benefit plan may provide or offer coverage required under this Section through a managed care plan.

(7) This Section shall not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(A) an addiction to a controlled substance or cannabis that is used in violation of law; or

(B) mental illness resulting from the use of a controlled substance or cannabis in violation of law.

(8) (Blank).

(c) This Section shall not be interpreted to require

coverage for speech therapy or other habilitative services for those individuals covered under Section 356z.11 of this Code. (Source: P.A. 94-402, eff. 8-2-05; 94-584, eff. 8-15-05; 94-906, eff. 1-1-07; 94-921, eff. 6-26-06; 95-331, eff. 8-21-07.)

Section 30. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11 ~~356z.9~~, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service

Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take

into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the

Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-4-07.)

Section 35. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356g.5, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11 ~~356z.9~~, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07; 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; revised 12-5-07.)

Section 40. The Illinois Public Aid Code is amended by changing Section 5-2 as follows:

(305 ILCS 5/5-2) (from Ch. 23, par. 5-2)

Sec. 5-2. Classes of Persons Eligible. Medical assistance under this Article shall be available to any of the following classes of persons in respect to whom a plan for coverage has been submitted to the Governor by the Illinois Department and

approved by him:

1. Recipients of basic maintenance grants under Articles III and IV.

2. Persons otherwise eligible for basic maintenance under Articles III and IV but who fail to qualify thereunder on the basis of need, and who have insufficient income and resources to meet the costs of necessary medical care, including but not limited to the following:

(a) All persons otherwise eligible for basic maintenance under Article III but who fail to qualify under that Article on the basis of need and who meet either of the following requirements:

(i) their income, as determined by the Illinois Department in accordance with any federal requirements, is equal to or less than 70% in fiscal year 2001, equal to or less than 85% in fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size; or

(ii) their income, after the deduction of

costs incurred for medical care and for other types of remedial care, is equal to or less than 70% in fiscal year 2001, equal to or less than 85% in fiscal year 2002 and until a date to be determined by the Department by rule, and equal to or less than 100% beginning on the date determined by the Department by rule, of the nonfarm income official poverty line, as defined in item (i) of this subparagraph (a).

(b) All persons who would be determined eligible for such basic maintenance under Article IV by disregarding the maximum earned income permitted by federal law.

3. Persons who would otherwise qualify for Aid to the Medically Indigent under Article VII.

4. Persons not eligible under any of the preceding paragraphs who fall sick, are injured, or die, not having sufficient money, property or other resources to meet the costs of necessary medical care or funeral and burial expenses.

5.(a) Women during pregnancy, after the fact of pregnancy has been determined by medical diagnosis, and during the 60-day period beginning on the last day of the pregnancy, together with their infants and children born after September 30, 1983, whose income and resources are insufficient to meet the costs of necessary medical care to

the maximum extent possible under Title XIX of the Federal Social Security Act.

(b) The Illinois Department and the Governor shall provide a plan for coverage of the persons eligible under paragraph 5(a) by April 1, 1990. Such plan shall provide ambulatory prenatal care to pregnant women during a presumptive eligibility period and establish an income eligibility standard that is equal to 133% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to families of the same size, provided that costs incurred for medical care are not taken into account in determining such income eligibility.

(c) The Illinois Department may conduct a demonstration in at least one county that will provide medical assistance to pregnant women, together with their infants and children up to one year of age, where the income eligibility standard is set up to 185% of the nonfarm income official poverty line, as defined by the federal Office of Management and Budget. The Illinois Department shall seek and obtain necessary authorization provided under federal law to implement such a demonstration. Such demonstration may establish resource standards that are not more restrictive than those

established under Article IV of this Code.

6. Persons under the age of 18 who fail to qualify as dependent under Article IV and who have insufficient income and resources to meet the costs of necessary medical care to the maximum extent permitted under Title XIX of the Federal Social Security Act.

7. Persons who are under 21 years of age and would qualify as disabled as defined under the Federal Supplemental Security Income Program, provided medical service for such persons would be eligible for Federal Financial Participation, and provided the Illinois Department determines that:

(a) the person requires a level of care provided by a hospital, skilled nursing facility, or intermediate care facility, as determined by a physician licensed to practice medicine in all its branches;

(b) it is appropriate to provide such care outside of an institution, as determined by a physician licensed to practice medicine in all its branches;

(c) the estimated amount which would be expended for care outside the institution is not greater than the estimated amount which would be expended in an institution.

8. Persons who become ineligible for basic maintenance assistance under Article IV of this Code in programs administered by the Illinois Department due to employment

earnings and persons in assistance units comprised of adults and children who become ineligible for basic maintenance assistance under Article VI of this Code due to employment earnings. The plan for coverage for this class of persons shall:

(a) extend the medical assistance coverage for up to 12 months following termination of basic maintenance assistance; and

(b) offer persons who have initially received 6 months of the coverage provided in paragraph (a) above, the option of receiving an additional 6 months of coverage, subject to the following:

(i) such coverage shall be pursuant to provisions of the federal Social Security Act;

(ii) such coverage shall include all services covered while the person was eligible for basic maintenance assistance;

(iii) no premium shall be charged for such coverage; and

(iv) such coverage shall be suspended in the event of a person's failure without good cause to file in a timely fashion reports required for this coverage under the Social Security Act and coverage shall be reinstated upon the filing of such reports if the person remains otherwise eligible.

9. Persons with acquired immunodeficiency syndrome (AIDS) or with AIDS-related conditions with respect to whom there has been a determination that but for home or community-based services such individuals would require the level of care provided in an inpatient hospital, skilled nursing facility or intermediate care facility the cost of which is reimbursed under this Article. Assistance shall be provided to such persons to the maximum extent permitted under Title XIX of the Federal Social Security Act.

10. Participants in the long-term care insurance partnership program established under the Illinois Long-Term Care Partnership Program Act ~~Partnership for Long Term Care Act~~ who meet the qualifications for protection of resources described in Section 15 ~~25~~ of that Act.

11. Persons with disabilities who are employed and eligible for Medicaid, pursuant to Section 1902(a)(10)(A)(ii)(xv) of the Social Security Act, as provided by the Illinois Department by rule. In establishing eligibility standards under this paragraph 11, the Department shall, subject to federal approval:

(a) set the income eligibility standard at not lower than 350% of the federal poverty level;

(b) exempt retirement accounts that the person cannot access without penalty before the age of 59 1/2,

and medical savings accounts established pursuant to 26 U.S.C. 220;

(c) allow non-exempt assets up to $25,000 as to those assets accumulated during periods of eligibility under this paragraph 11; and

(d) continue to apply subparagraphs (b) and (c) in determining the eligibility of the person under this Article even if the person loses eligibility under this paragraph 11.

12. Subject to federal approval, persons who are eligible for medical assistance coverage under applicable provisions of the federal Social Security Act and the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000. Those eligible persons are defined to include, but not be limited to, the following persons:

(1) persons who have been screened for breast or cervical cancer under the U.S. Centers for Disease Control and Prevention Breast and Cervical Cancer Program established under Title XV of the federal Public Health Services Act in accordance with the requirements of Section 1504 of that Act as administered by the Illinois Department of Public Health; and

(2) persons whose screenings under the above program were funded in whole or in part by funds appropriated to the Illinois Department of Public

Health for breast or cervical cancer screening.

"Medical assistance" under this paragraph 12 shall be identical to the benefits provided under the State's approved plan under Title XIX of the Social Security Act. The Department must request federal approval of the coverage under this paragraph 12 within 30 days after the effective date of this amendatory Act of the 92nd General Assembly.

13. Subject to appropriation and to federal approval, persons living with HIV/AIDS who are not otherwise eligible under this Article and who qualify for services covered under Section 5-5.04 as provided by the Illinois Department by rule.

14. Subject to the availability of funds for this purpose, the Department may provide coverage under this Article to persons who reside in Illinois who are not eligible under any of the preceding paragraphs and who meet the income guidelines of paragraph 2(a) of this Section and (i) have an application for asylum pending before the federal Department of Homeland Security or on appeal before a court of competent jurisdiction and are represented either by counsel or by an advocate accredited by the federal Department of Homeland Security and employed by a not-for-profit organization in regard to that application or appeal, or (ii) are receiving services through a federally funded torture treatment center. Medical

coverage under this paragraph 14 may be provided for up to 24 continuous months from the initial eligibility date so long as an individual continues to satisfy the criteria of this paragraph 14. If an individual has an appeal pending regarding an application for asylum before the Department of Homeland Security, eligibility under this paragraph 14 may be extended until a final decision is rendered on the appeal. The Department may adopt rules governing the implementation of this paragraph 14.

15. Subject to federal approval, persons with medically improved disability who are employed or eligible for Medicaid pursuant to Section 1902(a)(10)(A)(ii)(xvi) of the Social Security Act that meet applicable eligibility standards established in paragraph 11. The Department may not otherwise adopt any rule to implement this paragraph.

The Illinois Department and the Governor shall provide a plan for coverage of the persons eligible under paragraph 7 as soon as possible after July 1, 1984.

The eligibility of any such person for medical assistance under this Article is not affected by the payment of any grant under the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act or any distributions or items of income described under subparagraph (X) of paragraph (2) of subsection (a) of Section 203 of the Illinois Income Tax Act. The Department shall by rule establish the amounts of assets to be disregarded in determining eligibility

for medical assistance, which shall at a minimum equal the amounts to be disregarded under the Federal Supplemental Security Income Program. The amount of assets of a single person to be disregarded shall not be less than $2,000, and the amount of assets of a married couple to be disregarded shall not be less than $3,000.

To the extent permitted under federal law, any person found guilty of a second violation of Article VIIIA shall be ineligible for medical assistance under this Article, as provided in Section 8A-8.

The eligibility of any person for medical assistance under this Article shall not be affected by the receipt by the person of donations or benefits from fundraisers held for the person in cases of serious illness, as long as neither the person nor members of the person's family have actual control over the donations or benefits or the disbursement of the donations or benefits.

(Source: P.A. 94-629, eff. 1-1-06; 94-1043, eff. 7-24-06; 95-546, eff. 8-29-07; revised 1-22-08.)

Section 90. The State Mandates Act is amended by adding Section 8.32 as follows:

(30 ILCS 805/8.32 new)

Sec. 8.32. Exempt mandate. Notwithstanding Sections 6 and 8 of this Act, no reimbursement by the State is required for the

implementation of any mandate created by this amendatory Act of the 95th General Assembly.

Section 99. Effective date. This Act takes effect upon becoming law.".