

**101ST GENERAL ASSEMBLY
State of Illinois
2019 and 2020
HB0340**

Introduced , by Rep. Patrick Windhorst

SYNOPSIS AS INTRODUCED:

5 ILCS 375/6	from Ch. 127, par. 526
5 ILCS 375/6.1	from Ch. 127, par. 526.1
305 ILCS 5/5-5	from Ch. 23, par. 5-5
305 ILCS 5/5-8	from Ch. 23, par. 5-8
305 ILCS 5/5-9	from Ch. 23, par. 5-9
305 ILCS 5/6-1	from Ch. 23, par. 6-1
410 ILCS 230/4-100	from Ch. 111 1/2, par. 4604-100
720 ILCS 510/1	from Ch. 38, par. 81-21

Amends the State Employees Group Insurance Act of 1971, the Illinois Public Aid Code, the Problem Pregnancy Health Services and Care Act, and the Illinois Abortion Law of 1975. Restores the provisions that were amended by Public Act 100-538 to the form in which they existed before their amendment by Public Act 100-538.

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FISCAL NOTE ACT MAY
APPLY

A BILL FOR

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1 AN ACT concerning abortion.

2 Be it enacted by the People of the State of Illinois,
3 represented in the General Assembly:

4 Section 5. The State Employees Group Insurance Act of 1971
5 is amended by changing Sections 6 and 6.1 as follows:

6 (5 ILCS 375/6) (from Ch. 127, par. 526)
7 Sec. 6. Program of health benefits.

8 (a) The program of health benefits shall provide for
9 protection against the financial costs of health care expenses

10 incurred in and out of hospital including basic
11 hospital-surgical-medical coverages. The program may include,
12 but shall not be limited to, such supplemental coverages as
13 out-patient diagnostic X-ray and laboratory expenses,
14 prescription drugs, dental services, hearing evaluations,
15 hearing aids, the dispensing and fitting of hearing aids, and
16 similar group benefits as are now or may become available.
17 However, nothing in this Act shall be construed to permit the
18 non-contributory portion of any such program to include the
19 expenses of obtaining an abortion, induced miscarriage or
20 induced premature birth unless, in the opinion of a physician,
21 such procedures are necessary for the preservation of the life
22 of the woman seeking such treatment, or except an induced
23 premature birth intended to produce a live viable child and

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1 such procedure is necessary for the health of the mother or the
2 unborn child. The program may also include coverage for those
3 who rely on treatment by prayer or spiritual means alone for
4 healing in accordance with the tenets and practice of a
5 recognized religious denomination.

6 The program of health benefits shall be designed by the
7 Director (1) to provide a reasonable relationship between the
8 benefits to be included and the expected distribution of
9 expenses of each such type to be incurred by the covered
10 members and dependents, (2) to specify, as covered benefits and
11 as optional benefits, the medical services of practitioners in
12 all categories licensed under the Medical Practice Act of 1987,
13 (3) to include reasonable controls, which may include
14 deductible and co-insurance provisions, applicable to some or
15 all of the benefits, or a coordination of benefits provision,
16 to prevent or minimize unnecessary utilization of the various
17 hospital, surgical and medical expenses to be provided and to
18 provide reasonable assurance of stability of the program, and
19 (4) to provide benefits to the extent possible to members
20 throughout the State, wherever located, on an equitable basis.
21 Notwithstanding any other provision of this Section or Act, for
22 all members or dependents who are eligible for benefits under
23 Social Security or the Railroad Retirement system or who had
24 sufficient Medicare-covered government employment, the
25 Department shall reduce benefits which would otherwise be paid
26 by Medicare, by the amount of benefits for which the member or

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1 dependents are eligible under Medicare, except that such
2 reduction in benefits shall apply only to those members or
3 dependents who (1) first become eligible for such medicare
4 coverage on or after the effective date of this amendatory Act
5 of 1992; or (2) are Medicare-eligible members or dependents of
6 a local government unit which began participation in the
7 program on or after July 1, 1992; or (3) remain eligible for
8 but no longer receive Medicare coverage which they had been
9 receiving on or after the effective date of this amendatory Act
10 of 1992.

11 Notwithstanding any other provisions of this Act, where a
12 covered member or dependents are eligible for benefits under
13 the federal Medicare health insurance program (Title XVIII of
14 the Social Security Act as added by Public Law 89-97, 89th
15 Congress), benefits paid under the State of Illinois program or
16 plan will be reduced by the amount of benefits paid by
17 Medicare. For members or dependents who are eligible for
18 benefits under Social Security or the Railroad Retirement
19 system or who had sufficient Medicare-covered government
20 employment, benefits shall be reduced by the amount for which
21 the member or dependent is eligible under Medicare, except that
22 such reduction in benefits shall apply only to those members or
23 dependents who (1) first become eligible for such Medicare
24 coverage on or after the effective date of this amendatory Act
25 of 1992; or (2) are Medicare-eligible members or dependents of
26 a local government unit which began participation in the

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1 program on or after July 1, 1992; or (3) remain eligible for,
2 but no longer receive Medicare coverage which they had been
3 receiving on or after the effective date of this amendatory Act
4 of 1992. Premiums may be adjusted, where applicable, to an
5 amount deemed by the Director to be reasonably consistent with
6 any reduction of benefits.

7 (b) A member, not otherwise covered by this Act, who has
8 retired as a participating member under Article 2 of the
9 Illinois Pension Code but is ineligible for the retirement
10 annuity under Section 2-119 of the Illinois Pension Code, shall
11 pay the premiums for coverage, not exceeding the amount paid by
12 the State for the non-contributory coverage for other members,
13 under the group health benefits program under this Act. The
14 Director shall determine the premiums to be paid by a member
15 under this subsection (b).

16 (Source: P.A. 100-538, eff. 1-1-18.)

17 (5 ILCS 375/6.1) (from Ch. 127, par. 526.1)

18 Sec. 6.1. The program of health benefits may offer as an
19 alternative, available on an optional basis, coverage through
20 health maintenance organizations. That part of the premium for
21 such coverage which is in excess of the amount which would
22 otherwise be paid by the State for the program of health
23 benefits shall be paid by the member who elects such
24 alternative coverage and shall be collected as provided for
25 premiums for other optional coverages.

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1 However, nothing in this Act shall be construed to permit
2 the noncontributory portion of any such program to include the
3 expenses of obtaining an abortion, induced miscarriage or
4 induced premature birth unless, in the opinion of a physician,
5 such procedures are necessary for the preservation of the life
6 of the woman seeking such treatment, or except an induced
7 premature birth intended to produce a live viable child and
8 such procedure is necessary for the health of the mother or her
9 unborn child.

10 (Source: P.A. 100-538, eff. 1-1-18.)

11 Section 10. The Illinois Public Aid Code is amended by
12 changing Sections 5-5, 5-8, 5-9, and 6-1 as follows:

13 (305 ILCS 5/5-5) (from Ch. 23, par. 5-5)

14 Sec. 5-5. Medical services. The Illinois Department, by
15 rule, shall determine the quantity and quality of and the rate
16 of reimbursement for the medical assistance for which payment
17 will be authorized, and the medical services to be provided,
18 which may include all or part of the following: (1) inpatient
19 hospital services; (2) outpatient hospital services; (3) other
20 laboratory and X-ray services; (4) skilled nursing home
21 services; (5) physicians' services whether furnished in the
22 office, the patient's home, a hospital, a skilled nursing home,
23 or elsewhere; (6) medical care, or any other type of remedial
24 care furnished by licensed practitioners; (7) home health care

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1 services; (8) private duty nursing service; (9) clinic
2 services; (10) dental services, including prevention and
3 treatment of periodontal disease and dental caries disease for
4 pregnant women, provided by an individual licensed to practice
5 dentistry or dental surgery; for purposes of this item (10),
6 "dental services" means diagnostic, preventive, or corrective
7

8 procedures provided by or under the supervision of a dentist in
9 the practice of his or her profession; (11) physical therapy
10 and related services; (12) prescribed drugs, dentures, and
11 prosthetic devices; and eyeglasses prescribed by a physician
12 skilled in the diseases of the eye, or by an optometrist,
13 whichever the person may select; (13) other diagnostic,
14 screening, preventive, and rehabilitative services, including
15 to ensure that the individual's need for intervention or
16 treatment of mental disorders or substance use disorders or
17 co-occurring mental health and substance use disorders is
18 determined using a uniform screening, assessment, and
19 evaluation process inclusive of criteria, for children and
20 adults; for purposes of this item (13), a uniform screening,
21 assessment, and evaluation process refers to a process that
22 includes an appropriate evaluation and, as warranted, a
23 referral; "uniform" does not mean the use of a singular
24 instrument, tool, or process that all must utilize; (14)
25 transportation and such other expenses as may be necessary;
26 (15) medical treatment of sexual assault survivors, as defined
in Section 1a of the Sexual Assault Survivors Emergency

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1 Treatment Act, for injuries sustained as a result of the sexual
2 assault, including examinations and laboratory tests to
3 discover evidence which may be used in criminal proceedings
4 arising from the sexual assault; (16) the diagnosis and
5 treatment of sickle cell anemia; and (17) any other medical
6 care, and any other type of remedial care recognized under the
7 laws of this State, but not including abortions, or induced
8 miscarriages or premature births, unless, in the opinion of a
9 physician, such procedures are necessary for the preservation
10 of the life of the woman seeking such treatment, or except an
11 induced premature birth intended to produce a live viable child
12 and such procedure is necessary for the health of the mother or
13 her unborn child. The Illinois Department, by rule, shall
14 prohibit any physician from providing medical assistance to
15 anyone eligible therefor under this Code where such physician
16 has been found guilty of performing an abortion procedure in a
17 wilful and wanton manner upon a woman who was not pregnant at
18 the time such abortion procedure was performed. The term "any
19 other type of remedial care" shall include nursing care and
20 nursing home service for persons who rely on treatment by
21 spiritual means alone through prayer for healing.

22 Notwithstanding any other provision of this Section, a
23 comprehensive tobacco use cessation program that includes
24 purchasing prescription drugs or prescription medical devices

25 approved by the Food and Drug Administration shall be covered
26 under the medical assistance program under this Article for

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1 persons who are otherwise eligible for assistance under this
2 Article.

3 ~~Notwithstanding any other provision of this Code,~~
4 ~~reproductive health care that is otherwise legal in Illinois~~
5 ~~shall be covered under the medical assistance program for~~
6 ~~persons who are otherwise eligible for medical assistance under~~
7 ~~this Article.~~

8 Notwithstanding any other provision of this Code, the
9 Illinois Department may not require, as a condition of payment
10 for any laboratory test authorized under this Article, that a
11 physician's handwritten signature appear on the laboratory
12 test order form. The Illinois Department may, however, impose
13 other appropriate requirements regarding laboratory test order
14 documentation.

15 Upon receipt of federal approval of an amendment to the
16 Illinois Title XIX State Plan for this purpose, the Department
17 shall authorize the Chicago Public Schools (CPS) to procure a
18 vendor or vendors to manufacture eyeglasses for individuals
19 enrolled in a school within the CPS system. CPS shall ensure
20 that its vendor or vendors are enrolled as providers in the
21 medical assistance program and in any capitated Medicaid
22 managed care entity (MCE) serving individuals enrolled in a
23 school within the CPS system. Under any contract procured under
24 this provision, the vendor or vendors must serve only
25 individuals enrolled in a school within the CPS system. Claims
26 for services provided by CPS's vendor or vendors to recipients

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1 of benefits in the medical assistance program under this Code,
2 the Children's Health Insurance Program, or the Covering ALL
3 KIDS Health Insurance Program shall be submitted to the
4 Department or the MCE in which the individual is enrolled for
5 payment and shall be reimbursed at the Department's or the
6 MCE's established rates or rate methodologies for eyeglasses.

7 On and after July 1, 2012, the Department of Healthcare and
8 Family Services may provide the following services to persons
9 eligible for assistance under this Article who are
10 participating in education, training or employment programs
11 operated by the Department of Human Services as successor to
12 the Department of Public Aid:

13 (1) dental services provided by or under the
14 supervision of a dentist; and

15 (2) eyeglasses prescribed by a physician skilled in the
16 diseases of the eye, or by an optometrist, whichever the
17 person may select.

18 On and after July 1, 2018, the Department of Healthcare and
19 Family Services shall provide dental services to any adult who
20 is otherwise eligible for assistance under the medical
21 assistance program. As used in this paragraph, "dental
22 services" means diagnostic, preventative, restorative, or
23 corrective procedures, including procedures and services for
24 the prevention and treatment of periodontal disease and dental
25 caries disease, provided by an individual who is licensed to
26 practice dentistry or dental surgery or who is under the

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1 supervision of a dentist in the practice of his or her
2 profession.

3 On and after July 1, 2018, targeted dental services, as set
4 forth in Exhibit D of the Consent Decree entered by the United
5 States District Court for the Northern District of Illinois,
6 Eastern Division, in the matter of Memisovski v. Maram, Case
7 No. 92 C 1982, that are provided to adults under the medical
8 assistance program shall be established at no less than the
9 rates set forth in the "New Rate" column in Exhibit D of the
10 Consent Decree for targeted dental services that are provided
11 to persons under the age of 18 under the medical assistance
12 program.

13 Notwithstanding any other provision of this Code and
14 subject to federal approval, the Department may adopt rules to
15 allow a dentist who is volunteering his or her service at no
16 cost to render dental services through an enrolled
17 not-for-profit health clinic without the dentist personally
18 enrolling as a participating provider in the medical assistance
19 program. A not-for-profit health clinic shall include a public
20 health clinic or Federally Qualified Health Center or other
21 enrolled provider, as determined by the Department, through
22 which dental services covered under this Section are performed.
23 The Department shall establish a process for payment of claims
24 for reimbursement for covered dental services rendered under
25 this provision.

26 The Illinois Department, by rule, may distinguish and

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1 classify the medical services to be provided only in accordance
2 with the classes of persons designated in Section 5-2.

3 The Department of Healthcare and Family Services must
4 provide coverage and reimbursement for amino acid-based
5 elemental formulas, regardless of delivery method, for the
6 diagnosis and treatment of (i) eosinophilic disorders and (ii)
7 short bowel syndrome when the prescribing physician has issued
8 a written order stating that the amino acid-based elemental
9 formula is medically necessary.

10 The Illinois Department shall authorize the provision of,
11 and shall authorize payment for, screening by low-dose
12 mammography for the presence of occult breast cancer for women
13 35 years of age or older who are eligible for medical
14 assistance under this Article, as follows:

15 (A) A baseline mammogram for women 35 to 39 years of
16 age.

17 (B) An annual mammogram for women 40 years of age or
18 older.

19 (C) A mammogram at the age and intervals considered
20 medically necessary by the woman's health care provider for
21 women under 40 years of age and having a family history of
22 breast cancer, prior personal history of breast cancer,
23 positive genetic testing, or other risk factors.

24 (D) A comprehensive ultrasound screening and MRI of an
25 entire breast or breasts if a mammogram demonstrates
26 heterogeneous or dense breast tissue, when medically

1 necessary as determined by a physician licensed to practice
2 medicine in all of its branches.

3 (E) A screening MRI when medically necessary, as
4 determined by a physician licensed to practice medicine in
5 all of its branches.

6 All screenings shall include a physical breast exam,
7 instruction on self-examination and information regarding the
8 frequency of self-examination and its value as a preventative
9 tool. For purposes of this Section, "low-dose mammography"
10 means the x-ray examination of the breast using equipment
11 dedicated specifically for mammography, including the x-ray
12 tube, filter, compression device, and image receptor, with an
13 average radiation exposure delivery of less than one rad per
14 breast for 2 views of an average size breast. The term also
15 includes digital mammography and includes breast
16 tomosynthesis. As used in this Section, the term "breast
17 tomosynthesis" means a radiologic procedure that involves the
18 acquisition of projection images over the stationary breast to

19 produce cross-sectional digital three-dimensional images of
20 the breast. If, at any time, the Secretary of the United States
21 Department of Health and Human Services, or its successor
22 agency, promulgates rules or regulations to be published in the
23 Federal Register or publishes a comment in the Federal Register
24 or issues an opinion, guidance, or other action that would
25 require the State, pursuant to any provision of the Patient
26 Protection and Affordable Care Act (Public Law 111-148),

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1 including, but not limited to, 42 U.S.C. 18031(d)(3)(B) or any
2 successor provision, to defray the cost of any coverage for
3 breast tomosynthesis outlined in this paragraph, then the
4 requirement that an insurer cover breast tomosynthesis is
5 inoperative other than any such coverage authorized under
6 Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and
7 the State shall not assume any obligation for the cost of
8 coverage for breast tomosynthesis set forth in this paragraph.

9 On and after January 1, 2016, the Department shall ensure
10 that all networks of care for adult clients of the Department
11 include access to at least one breast imaging Center of Imaging
12 Excellence as certified by the American College of Radiology.

13 On and after January 1, 2012, providers participating in a
14 quality improvement program approved by the Department shall be
15 reimbursed for screening and diagnostic mammography at the same
16 rate as the Medicare program's rates, including the increased
17 reimbursement for digital mammography.

18 The Department shall convene an expert panel including
19 representatives of hospitals, free-standing mammography
20 facilities, and doctors, including radiologists, to establish
21 quality standards for mammography.

22 On and after January 1, 2017, providers participating in a
23 breast cancer treatment quality improvement program approved
24 by the Department shall be reimbursed for breast cancer
25 treatment at a rate that is no lower than 95% of the Medicare
26 program's rates for the data elements included in the breast

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1 cancer treatment quality program.

2 The Department shall convene an expert panel, including
3 representatives of hospitals, free-standing breast cancer
4 treatment centers, breast cancer quality organizations, and
5 doctors, including breast surgeons, reconstructive breast
6 surgeons, oncologists, and primary care providers to establish

7 quality standards for breast cancer treatment.

8 Subject to federal approval, the Department shall
9 establish a rate methodology for mammography at federally
10 qualified health centers and other encounter-rate clinics.
11 These clinics or centers may also collaborate with other
12 hospital-based mammography facilities. By January 1, 2016, the
13 Department shall report to the General Assembly on the status
14 of the provision set forth in this paragraph.

15 The Department shall establish a methodology to remind
16 women who are age-appropriate for screening mammography, but
17 who have not received a mammogram within the previous 18
18 months, of the importance and benefit of screening mammography.
19 The Department shall work with experts in breast cancer
20 outreach and patient navigation to optimize these reminders and
21 shall establish a methodology for evaluating their
22 effectiveness and modifying the methodology based on the
23 evaluation.

24 The Department shall establish a performance goal for
25 primary care providers with respect to their female patients
26 over age 40 receiving an annual mammogram. This performance

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1 goal shall be used to provide additional reimbursement in the
2 form of a quality performance bonus to primary care providers
3 who meet that goal.

4 The Department shall devise a means of case-managing or
5 patient navigation for beneficiaries diagnosed with breast
6 cancer. This program shall initially operate as a pilot program
7 in areas of the State with the highest incidence of mortality
8 related to breast cancer. At least one pilot program site shall
9 be in the metropolitan Chicago area and at least one site shall
10 be outside the metropolitan Chicago area. On or after July 1,
11 2016, the pilot program shall be expanded to include one site
12 in western Illinois, one site in southern Illinois, one site in
13 central Illinois, and 4 sites within metropolitan Chicago. An
14 evaluation of the pilot program shall be carried out measuring
15 health outcomes and cost of care for those served by the pilot
16 program compared to similarly situated patients who are not
17 served by the pilot program.

18 The Department shall require all networks of care to
19 develop a means either internally or by contract with experts
20 in navigation and community outreach to navigate cancer
21 patients to comprehensive care in a timely fashion. The
22 Department shall require all networks of care to include access
23 for patients diagnosed with cancer to at least one academic
24 commission on cancer-accredited cancer program as an

25 in-network covered benefit.

26 Any medical or health care provider shall immediately

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1 recommend, to any pregnant woman who is being provided prenatal
2 services and is suspected of having a substance use disorder as
3 defined in the Substance Use Disorder Act, referral to a local
4 substance use disorder treatment program licensed by the
5 Department of Human Services or to a licensed hospital which
6 provides substance abuse treatment services. The Department of
7 Healthcare and Family Services shall assure coverage for the
8 cost of treatment of the drug abuse or addiction for pregnant
9 recipients in accordance with the Illinois Medicaid Program in
10 conjunction with the Department of Human Services.

11 All medical providers providing medical assistance to
12 pregnant women under this Code shall receive information from
13 the Department on the availability of services under any
14 program providing case management services for addicted women,
15 including information on appropriate referrals for other
16 social services that may be needed by addicted women in
17 addition to treatment for addiction.

18 The Illinois Department, in cooperation with the
19 Departments of Human Services (as successor to the Department
20 of Alcoholism and Substance Abuse) and Public Health, through a
21 public awareness campaign, may provide information concerning
22 treatment for alcoholism and drug abuse and addiction, prenatal
23 health care, and other pertinent programs directed at reducing
24 the number of drug-affected infants born to recipients of
25 medical assistance.

26 Neither the Department of Healthcare and Family Services

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1 nor the Department of Human Services shall sanction the
2 recipient solely on the basis of her substance abuse.

3 The Illinois Department shall establish such regulations
4 governing the dispensing of health services under this Article
5 as it shall deem appropriate. The Department should seek the
6 advice of formal professional advisory committees appointed by
7 the Director of the Illinois Department for the purpose of
8 providing regular advice on policy and administrative matters,
9 information dissemination and educational activities for
10 medical and health care providers, and consistency in
11 procedures to the Illinois Department.

12 The Illinois Department may develop and contract with

13 Partnerships of medical providers to arrange medical services
14 for persons eligible under Section 5-2 of this Code.
15 Implementation of this Section may be by demonstration projects
16 in certain geographic areas. The Partnership shall be
17 represented by a sponsor organization. The Department, by rule,
18 shall develop qualifications for sponsors of Partnerships.
19 Nothing in this Section shall be construed to require that the
20 sponsor organization be a medical organization.

21 The sponsor must negotiate formal written contracts with
22 medical providers for physician services, inpatient and
23 outpatient hospital care, home health services, treatment for
24 alcoholism and substance abuse, and other services determined
25 necessary by the Illinois Department by rule for delivery by
26 Partnerships. Physician services must include prenatal and

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1 obstetrical care. The Illinois Department shall reimburse
2 medical services delivered by Partnership providers to clients
3 in target areas according to provisions of this Article and the
4 Illinois Health Finance Reform Act, except that:

5 (1) Physicians participating in a Partnership and
6 providing certain services, which shall be determined by
7 the Illinois Department, to persons in areas covered by the
8 Partnership may receive an additional surcharge for such
9 services.

10 (2) The Department may elect to consider and negotiate
11 financial incentives to encourage the development of
12 Partnerships and the efficient delivery of medical care.

13 (3) Persons receiving medical services through
14 Partnerships may receive medical and case management
15 services above the level usually offered through the
16 medical assistance program.

17 Medical providers shall be required to meet certain
18 qualifications to participate in Partnerships to ensure the
19 delivery of high quality medical services. These
20 qualifications shall be determined by rule of the Illinois
21 Department and may be higher than qualifications for
22 participation in the medical assistance program. Partnership
23 sponsors may prescribe reasonable additional qualifications
24 for participation by medical providers, only with the prior
25 written approval of the Illinois Department.

26 Nothing in this Section shall limit the free choice of

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1 practitioners, hospitals, and other providers of medical
2 services by clients. In order to ensure patient freedom of
3 choice, the Illinois Department shall immediately promulgate
4 all rules and take all other necessary actions so that provided
5 services may be accessed from therapeutically certified
6 optometrists to the full extent of the Illinois Optometric
7 Practice Act of 1987 without discriminating between service
8 providers.

9 The Department shall apply for a waiver from the United
10 States Health Care Financing Administration to allow for the
11 implementation of Partnerships under this Section.

12 The Illinois Department shall require health care
13 providers to maintain records that document the medical care
14 and services provided to recipients of Medical Assistance under
15 this Article. Such records must be retained for a period of not
16 less than 6 years from the date of service or as provided by
17 applicable State law, whichever period is longer, except that
18 if an audit is initiated within the required retention period
19 then the records must be retained until the audit is completed
20 and every exception is resolved. The Illinois Department shall
21 require health care providers to make available, when
22 authorized by the patient, in writing, the medical records in a
23 timely fashion to other health care providers who are treating
24 or serving persons eligible for Medical Assistance under this
25 Article. All dispensers of medical services shall be required
26 to maintain and retain business and professional records

1 sufficient to fully and accurately document the nature, scope,
2 details and receipt of the health care provided to persons
3 eligible for medical assistance under this Code, in accordance
4 with regulations promulgated by the Illinois Department. The
5 rules and regulations shall require that proof of the receipt
6 of prescription drugs, dentures, prosthetic devices and
7 eyeglasses by eligible persons under this Section accompany
8 each claim for reimbursement submitted by the dispenser of such
9 medical services. No such claims for reimbursement shall be
10 approved for payment by the Illinois Department without such
11 proof of receipt, unless the Illinois Department shall have put
12 into effect and shall be operating a system of post-payment
13 audit and review which shall, on a sampling basis, be deemed
14 adequate by the Illinois Department to assure that such drugs,
15 dentures, prosthetic devices and eyeglasses for which payment
16 is being made are actually being received by eligible
17 recipients. Within 90 days after September 16, 1984 (the
18 effective date of Public Act 83-1439), the Illinois Department

19 shall establish a current list of acquisition costs for all
20 prosthetic devices and any other items recognized as medical
21 equipment and supplies reimbursable under this Article and
22 shall update such list on a quarterly basis, except that the
23 acquisition costs of all prescription drugs shall be updated no
24 less frequently than every 30 days as required by Section
25 5-5.12.

26 The rules and regulations of the Illinois Department shall

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1 require that a written statement including the required opinion
2 of a physician shall accompany any claim for reimbursement for
3 abortions, or induced miscarriages or premature births. This
4 statement shall indicate what procedures were used in providing
5 such medical services.

6 Notwithstanding any other law to the contrary, the Illinois
7 Department shall, within 365 days after July 22, 2013 (the
8 effective date of Public Act 98-104), establish procedures to
9 permit skilled care facilities licensed under the Nursing Home
10 Care Act to submit monthly billing claims for reimbursement
11 purposes. Following development of these procedures, the
12 Department shall, by July 1, 2016, test the viability of the
13 new system and implement any necessary operational or
14 structural changes to its information technology platforms in
15 order to allow for the direct acceptance and payment of nursing
16 home claims.

17 Notwithstanding any other law to the contrary, the Illinois
18 Department shall, within 365 days after August 15, 2014 (the
19 effective date of Public Act 98-963), establish procedures to
20 permit ID/DD facilities licensed under the ID/DD Community Care
21 Act and MC/DD facilities licensed under the MC/DD Act to submit
22 monthly billing claims for reimbursement purposes. Following
23 development of these procedures, the Department shall have an
24 additional 365 days to test the viability of the new system and
25 to ensure that any necessary operational or structural changes
26 to its information technology platforms are implemented.

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1 The Illinois Department shall require all dispensers of
2 medical services, other than an individual practitioner or
3 group of practitioners, desiring to participate in the Medical
4 Assistance program established under this Article to disclose
5 all financial, beneficial, ownership, equity, surety or other
6 interests in any and all firms, corporations, partnerships,

7 associations, business enterprises, joint ventures, agencies,
8 institutions or other legal entities providing any form of
9 health care services in this State under this Article.

10 The Illinois Department may require that all dispensers of
11 medical services desiring to participate in the medical
12 assistance program established under this Article disclose,
13 under such terms and conditions as the Illinois Department may
14 by rule establish, all inquiries from clients and attorneys
15 regarding medical bills paid by the Illinois Department, which
16 inquiries could indicate potential existence of claims or liens
17 for the Illinois Department.

18 Enrollment of a vendor shall be subject to a provisional
19 period and shall be conditional for one year. During the period
20 of conditional enrollment, the Department may terminate the
21 vendor's eligibility to participate in, or may disenroll the
22 vendor from, the medical assistance program without cause.
23 Unless otherwise specified, such termination of eligibility or
24 disenrollment is not subject to the Department's hearing
25 process. However, a disenrolled vendor may reapply without
26 penalty.

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1 The Department has the discretion to limit the conditional
2 enrollment period for vendors based upon category of risk of
3 the vendor.

4 Prior to enrollment and during the conditional enrollment
5 period in the medical assistance program, all vendors shall be
6 subject to enhanced oversight, screening, and review based on
7 the risk of fraud, waste, and abuse that is posed by the
8 category of risk of the vendor. The Illinois Department shall
9 establish the procedures for oversight, screening, and review,
10 which may include, but need not be limited to: criminal and
11 financial background checks; fingerprinting; license,
12 certification, and authorization verifications; unscheduled or
13 unannounced site visits; database checks; prepayment audit
14 reviews; audits; payment caps; payment suspensions; and other
15 screening as required by federal or State law.

16 The Department shall define or specify the following: (i)
17 by provider notice, the "category of risk of the vendor" for
18 each type of vendor, which shall take into account the level of
19 screening applicable to a particular category of vendor under
20 federal law and regulations; (ii) by rule or provider notice,
21 the maximum length of the conditional enrollment period for
22 each category of risk of the vendor; and (iii) by rule, the
23 hearing rights, if any, afforded to a vendor in each category
24 of risk of the vendor that is terminated or disenrolled during

25 the conditional enrollment period.

26 To be eligible for payment consideration, a vendor's

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1 payment claim or bill, either as an initial claim or as a
2 resubmitted claim following prior rejection, must be received
3 by the Illinois Department, or its fiscal intermediary, no
4 later than 180 days after the latest date on the claim on which
5 medical goods or services were provided, with the following
6 exceptions:

7 (1) In the case of a provider whose enrollment is in
8 process by the Illinois Department, the 180-day period
9 shall not begin until the date on the written notice from
10 the Illinois Department that the provider enrollment is
11 complete.

12 (2) In the case of errors attributable to the Illinois
13 Department or any of its claims processing intermediaries
14 which result in an inability to receive, process, or
15 adjudicate a claim, the 180-day period shall not begin
16 until the provider has been notified of the error.

17 (3) In the case of a provider for whom the Illinois
18 Department initiates the monthly billing process.

19 (4) In the case of a provider operated by a unit of
20 local government with a population exceeding 3,000,000
21 when local government funds finance federal participation
22 for claims payments.

23 For claims for services rendered during a period for which
24 a recipient received retroactive eligibility, claims must be
25 filed within 180 days after the Department determines the
26 applicant is eligible. For claims for which the Illinois

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1 Department is not the primary payer, claims must be submitted
2 to the Illinois Department within 180 days after the final
3 adjudication by the primary payer.

4 In the case of long term care facilities, within 45
5 calendar days of receipt by the facility of required
6 prescreening information, new admissions with associated
7 admission documents shall be submitted through the Medical
8 Electronic Data Interchange (MEDI) or the Recipient
9 Eligibility Verification (REV) System or shall be submitted
10 directly to the Department of Human Services using required
11 admission forms. Effective September 1, 2014, admission
12 documents, including all prescreening information, must be

13 submitted through MEDI or REV. Confirmation numbers assigned to
14 an accepted transaction shall be retained by a facility to
15 verify timely submittal. Once an admission transaction has been
16 completed, all resubmitted claims following prior rejection
17 are subject to receipt no later than 180 days after the
18 admission transaction has been completed.

19 Claims that are not submitted and received in compliance
20 with the foregoing requirements shall not be eligible for
21 payment under the medical assistance program, and the State
22 shall have no liability for payment of those claims.

23 To the extent consistent with applicable information and
24 privacy, security, and disclosure laws, State and federal
25 agencies and departments shall provide the Illinois Department
26 access to confidential and other information and data necessary

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1 to perform eligibility and payment verifications and other
2 Illinois Department functions. This includes, but is not
3 limited to: information pertaining to licensure;
4 certification; earnings; immigration status; citizenship; wage
5 reporting; unearned and earned income; pension income;
6 employment; supplemental security income; social security
7 numbers; National Provider Identifier (NPI) numbers; the
8 National Practitioner Data Bank (NPDB); program and agency
9 exclusions; taxpayer identification numbers; tax delinquency;
10 corporate information; and death records.

11 The Illinois Department shall enter into agreements with
12 State agencies and departments, and is authorized to enter into
13 agreements with federal agencies and departments, under which
14 such agencies and departments shall share data necessary for
15 medical assistance program integrity functions and oversight.
16 The Illinois Department shall develop, in cooperation with
17 other State departments and agencies, and in compliance with
18 applicable federal laws and regulations, appropriate and
19 effective methods to share such data. At a minimum, and to the
20 extent necessary to provide data sharing, the Illinois
21 Department shall enter into agreements with State agencies and
22 departments, and is authorized to enter into agreements with
23 federal agencies and departments, including but not limited to:
24 the Secretary of State; the Department of Revenue; the
25 Department of Public Health; the Department of Human Services;
26 and the Department of Financial and Professional Regulation.

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1 Beginning in fiscal year 2013, the Illinois Department
2 shall set forth a request for information to identify the
3 benefits of a pre-payment, post-adjudication, and post-edit
4 claims system with the goals of streamlining claims processing
5 and provider reimbursement, reducing the number of pending or
6 rejected claims, and helping to ensure a more transparent
7 adjudication process through the utilization of: (i) provider
8 data verification and provider screening technology; and (ii)
9 clinical code editing; and (iii) pre-pay, pre- or
10 post-adjudicated predictive modeling with an integrated case
11 management system with link analysis. Such a request for
12 information shall not be considered as a request for proposal
13 or as an obligation on the part of the Illinois Department to
14 take any action or acquire any products or services.

15 The Illinois Department shall establish policies,
16 procedures, standards and criteria by rule for the acquisition,
17 repair and replacement of orthotic and prosthetic devices and
18 durable medical equipment. Such rules shall provide, but not be
19 limited to, the following services: (1) immediate repair or
20 replacement of such devices by recipients; and (2) rental,
21 lease, purchase or lease-purchase of durable medical equipment
22 in a cost-effective manner, taking into consideration the
23 recipient's medical prognosis, the extent of the recipient's
24 needs, and the requirements and costs for maintaining such
25 equipment. Subject to prior approval, such rules shall enable a
26 recipient to temporarily acquire and use alternative or

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1 substitute devices or equipment pending repairs or
2 replacements of any device or equipment previously authorized
3 for such recipient by the Department. Notwithstanding any
4 provision of Section 5-5f to the contrary, the Department may,
5 by rule, exempt certain replacement wheelchair parts from prior
6 approval and, for wheelchairs, wheelchair parts, wheelchair
7 accessories, and related seating and positioning items,
8 determine the wholesale price by methods other than actual
9 acquisition costs.

10 The Department shall require, by rule, all providers of
11 durable medical equipment to be accredited by an accreditation
12 organization approved by the federal Centers for Medicare and
13 Medicaid Services and recognized by the Department in order to
14 bill the Department for providing durable medical equipment to
15 recipients. No later than 15 months after the effective date of
16 the rule adopted pursuant to this paragraph, all providers must
17 meet the accreditation requirement.

18 In order to promote environmental responsibility, meet the

19 needs of recipients and enrollees, and achieve significant cost
20 savings, the Department, or a managed care organization under
21 contract with the Department, may provide recipients or managed
22 care enrollees who have a prescription or Certificate of
23 Medical Necessity access to refurbished durable medical
24 equipment under this Section (excluding prosthetic and
25 orthotic devices as defined in the Orthotics, Prosthetics, and
26 Pedorthics Practice Act and complex rehabilitation technology

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1 products and associated services) through the State's
2 assistive technology program's reutilization program, using
3 staff with the Assistive Technology Professional (ATP)
4 Certification if the refurbished durable medical equipment:
5 (i) is available; (ii) is less expensive, including shipping
6 costs, than new durable medical equipment of the same type;
7 (iii) is able to withstand at least 3 years of use; (iv) is
8 cleaned, disinfected, sterilized, and safe in accordance with
9 federal Food and Drug Administration regulations and guidance
10 governing the reprocessing of medical devices in health care
11 settings; and (v) equally meets the needs of the recipient or
12 enrollee. The reutilization program shall confirm that the
13 recipient or enrollee is not already in receipt of same or
14 similar equipment from another service provider, and that the
15 refurbished durable medical equipment equally meets the needs
16 of the recipient or enrollee. Nothing in this paragraph shall
17 be construed to limit recipient or enrollee choice to obtain
18 new durable medical equipment or place any additional prior
19 authorization conditions on enrollees of managed care
20 organizations.

21 The Department shall execute, relative to the nursing home
22 prescreening project, written inter-agency agreements with the
23 Department of Human Services and the Department on Aging, to
24 effect the following: (i) intake procedures and common
25 eligibility criteria for those persons who are receiving
26 non-institutional services; and (ii) the establishment and

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1 development of non-institutional services in areas of the State
2 where they are not currently available or are undeveloped; and
3 (iii) notwithstanding any other provision of law, subject to
4 federal approval, on and after July 1, 2012, an increase in the
5 determination of need (DON) scores from 29 to 37 for applicants
6 for institutional and home and community-based long term care;

7 if and only if federal approval is not granted, the Department
8 may, in conjunction with other affected agencies, implement
9 utilization controls or changes in benefit packages to
10 effectuate a similar savings amount for this population; and
11 (iv) no later than July 1, 2013, minimum level of care
12 eligibility criteria for institutional and home and
13 community-based long term care; and (v) no later than October
14 1, 2013, establish procedures to permit long term care
15 providers access to eligibility scores for individuals with an
16 admission date who are seeking or receiving services from the
17 long term care provider. In order to select the minimum level
18 of care eligibility criteria, the Governor shall establish a
19 workgroup that includes affected agency representatives and
20 stakeholders representing the institutional and home and
21 community-based long term care interests. This Section shall
22 not restrict the Department from implementing lower level of
23 care eligibility criteria for community-based services in
24 circumstances where federal approval has been granted.

25 The Illinois Department shall develop and operate, in
26 cooperation with other State Departments and agencies and in

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1 compliance with applicable federal laws and regulations,
2 appropriate and effective systems of health care evaluation and
3 programs for monitoring of utilization of health care services
4 and facilities, as it affects persons eligible for medical
5 assistance under this Code.

6 The Illinois Department shall report annually to the
7 General Assembly, no later than the second Friday in April of
8 1979 and each year thereafter, in regard to:

9 (a) actual statistics and trends in utilization of
10 medical services by public aid recipients;

11 (b) actual statistics and trends in the provision of
12 the various medical services by medical vendors;

13 (c) current rate structures and proposed changes in
14 those rate structures for the various medical vendors; and

15 (d) efforts at utilization review and control by the
16 Illinois Department.

17 The period covered by each report shall be the 3 years
18 ending on the June 30 prior to the report. The report shall
19 include suggested legislation for consideration by the General
20 Assembly. The requirement for reporting to the General Assembly
21 shall be satisfied by filing copies of the report as required
22 by Section 3.1 of the General Assembly Organization Act, and
23 filing such additional copies with the State Government Report
24 Distribution Center for the General Assembly as is required

25 under paragraph (t) of Section 7 of the State Library Act.

26 Rulemaking authority to implement Public Act 95-1045, if

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1 any, is conditioned on the rules being adopted in accordance
2 with all provisions of the Illinois Administrative Procedure
3 Act and all rules and procedures of the Joint Committee on
4 Administrative Rules; any purported rule not so adopted, for
5 whatever reason, is unauthorized.

6 On and after July 1, 2012, the Department shall reduce any
7 rate of reimbursement for services or other payments or alter
8 any methodologies authorized by this Code to reduce any rate of
9 reimbursement for services or other payments in accordance with
10 Section 5-5e.

11 Because kidney transplantation can be an appropriate,
12 cost-effective alternative to renal dialysis when medically
13 necessary and notwithstanding the provisions of Section 1-11 of
14 this Code, beginning October 1, 2014, the Department shall
15 cover kidney transplantation for noncitizens with end-stage
16 renal disease who are not eligible for comprehensive medical
17 benefits, who meet the residency requirements of Section 5-3 of
18 this Code, and who would otherwise meet the financial
19 requirements of the appropriate class of eligible persons under
20 Section 5-2 of this Code. To qualify for coverage of kidney
21 transplantation, such person must be receiving emergency renal
22 dialysis services covered by the Department. Providers under
23 this Section shall be prior approved and certified by the
24 Department to perform kidney transplantation and the services
25 under this Section shall be limited to services associated with
26 kidney transplantation.

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1 Notwithstanding any other provision of this Code to the
2 contrary, on or after July 1, 2015, all FDA approved forms of
3 medication assisted treatment prescribed for the treatment of
4 alcohol dependence or treatment of opioid dependence shall be
5 covered under both fee for service and managed care medical
6 assistance programs for persons who are otherwise eligible for
7 medical assistance under this Article and shall not be subject
8 to any (1) utilization control, other than those established
9 under the American Society of Addiction Medicine patient
10 placement criteria, (2) prior authorization mandate, or (3)
11 lifetime restriction limit mandate.

12 On or after July 1, 2015, opioid antagonists prescribed for

13 the treatment of an opioid overdose, including the medication
14 product, administration devices, and any pharmacy fees related
15 to the dispensing and administration of the opioid antagonist,
16 shall be covered under the medical assistance program for
17 persons who are otherwise eligible for medical assistance under
18 this Article. As used in this Section, "opioid antagonist"
19 means a drug that binds to opioid receptors and blocks or
20 inhibits the effect of opioids acting on those receptors,
21 including, but not limited to, naloxone hydrochloride or any
22 other similarly acting drug approved by the U.S. Food and Drug
23 Administration.

24 Upon federal approval, the Department shall provide
25 coverage and reimbursement for all drugs that are approved for
26 marketing by the federal Food and Drug Administration and that

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1 are recommended by the federal Public Health Service or the
2 United States Centers for Disease Control and Prevention for
3 pre-exposure prophylaxis and related pre-exposure prophylaxis
4 services, including, but not limited to, HIV and sexually
5 transmitted infection screening, treatment for sexually
6 transmitted infections, medical monitoring, assorted labs, and
7 counseling to reduce the likelihood of HIV infection among
8 individuals who are not infected with HIV but who are at high
9 risk of HIV infection.

10 A federally qualified health center, as defined in Section
11 1905(1)(2)(B) of the federal Social Security Act, shall be
12 reimbursed by the Department in accordance with the federally
13 qualified health center's encounter rate for services provided
14 to medical assistance recipients that are performed by a dental
15 hygienist, as defined under the Illinois Dental Practice Act,
16 working under the general supervision of a dentist and employed
17 by a federally qualified health center.

18 Notwithstanding any other provision of this Code, the
19 Illinois Department shall authorize licensed dietitian
20 nutritionists and certified diabetes educators to counsel
21 senior diabetes patients in the senior diabetes patients' homes
22 to remove the hurdle of transportation for senior diabetes
23 patients to receive treatment.

24 (Source: P.A. 99-78, eff. 7-20-15; 99-180, eff. 7-29-15;
25 99-236, eff. 8-3-15; 99-407 (see Section 20 of P.A. 99-588 for
26 the effective date of P.A. 99-407); 99-433, eff. 8-21-15;

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1 99-480, eff. 9-9-15; 99-588, eff. 7-20-16; 99-642, eff.
2 7-28-16; 99-772, eff. 1-1-17; 99-895, eff. 1-1-17; 100-201,
3 eff. 8-18-17; 100-395, eff. 1-1-18; 100-449, eff. 1-1-18;
4 100-538, eff. 1-1-18; 100-587, eff. 6-4-18; 100-759, eff.
5 1-1-19; 100-863, eff. 8-14-18; 100-974, eff. 8-19-18;
6 100-1009, eff. 1-1-19; 100-1018, eff. 1-1-19; 100-1148, eff.
7 12-10-18.)

8 (305 ILCS 5/5-8) (from Ch. 23, par. 5-8)

9 Sec. 5-8. Practitioners. In supplying medical assistance,
10 the Illinois Department may provide for the legally authorized
11 services of (i) persons licensed under the Medical Practice Act
12 of 1987, as amended, except as hereafter in this Section
13 stated, whether under a general or limited license, (ii)
14 persons licensed under the Nurse Practice Act as advanced
15 practice registered nurses, regardless of whether or not the
16 persons have written collaborative agreements, (iii) persons
17 licensed or registered under other laws of this State to
18 provide dental, medical, pharmaceutical, optometric,
19 podiatric, or nursing services, or other remedial care
20 recognized under State law, (iv) persons licensed under other
21 laws of this State as a clinical social worker, and (v) persons
22 licensed under other laws of this State as physician
23 assistants. The Department shall adopt rules, no later than 90
24 days after January 1, 2017 (the effective date of Public Act
25 99-621), for the legally authorized services of persons

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1 licensed under other laws of this State as a clinical social
2 worker. The Department may not provide for legally authorized
3 services of any physician who has been convicted of having
4 performed an abortion procedure in a wilful and wanton manner
5 on a woman who was not pregnant at the time such abortion
6 procedure was performed. The utilization of the services of
7 persons engaged in the treatment or care of the sick, which
8 persons are not required to be licensed or registered under the
9 laws of this State, is not prohibited by this Section.
10 (Source: P.A. 99-173, eff. 7-29-15; 99-621, eff. 1-1-17;
11 100-453, eff. 8-25-17; 100-513, eff. 1-1-18; 100-538, eff.
12 1-1-18; 100-863, eff. 8-14-18.)

13 (305 ILCS 5/5-9) (from Ch. 23, par. 5-9)

14 Sec. 5-9. Choice of medical dispensers. Applicants and
15 recipients shall be entitled to free choice of those qualified
16 practitioners, hospitals, nursing homes, and other dispensers
17 of medical services meeting the requirements and complying with
18 the rules and regulations of the Illinois Department. However,

19 the Director of Healthcare and Family Services may, after
20 providing reasonable notice and opportunity for hearing, deny,
21 suspend or terminate any otherwise qualified person, firm,
22 corporation, association, agency, institution, or other legal
23 entity, from participation as a vendor of goods or services
24 under the medical assistance program authorized by this Article
25 if the Director finds such vendor of medical services in

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1 violation of this Act or the policy or rules and regulations
2 issued pursuant to this Act. Any physician who has been
3 convicted of performing an abortion procedure in a wilful and
4 wanton manner upon a woman who was not pregnant at the time
5 such abortion procedure was performed shall be automatically
6 removed from the list of physicians qualified to participate as
7 a vendor of medical services under the medical assistance
8 program authorized by this Article.

9 (Source: P.A. 100-538, eff. 1-1-18.)

10 (305 ILCS 5/6-1) (from Ch. 23, par. 6-1)

11 Sec. 6-1. Eligibility requirements. Financial aid in
12 meeting basic maintenance requirements shall be given under
13 this Article to or in behalf of persons who meet the
14 eligibility conditions of Sections 6-1.1 through 6-1.10. In
15 addition, each unit of local government subject to this Article
16 shall provide persons receiving financial aid in meeting basic
17 maintenance requirements with financial aid for either (a)
18 necessary treatment, care, and supplies required because of
19 illness or disability, or (b) acute medical treatment, care,
20 and supplies only. If a local governmental unit elects to
21 provide financial aid for acute medical treatment, care, and
22 supplies only, the general types of acute medical treatment,
23 care, and supplies for which financial aid is provided shall be
24 specified in the general assistance rules of the local
25 governmental unit, which rules shall provide that financial aid

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1 is provided, at a minimum, for acute medical treatment, care,
2 or supplies necessitated by a medical condition for which prior
3 approval or authorization of medical treatment, care, or
4 supplies is not required by the general assistance rules of the
5 Illinois Department. Nothing in this Article shall be construed
6 to permit the granting of financial aid where the purpose of
7 such aid is to obtain an abortion, induced miscarriage or

8 induced premature birth unless, in the opinion of a physician,
9 such procedures are necessary for the preservation of the life
10 of the woman seeking such treatment, or except an induced
11 premature birth intended to produce a live viable child and
12 such procedure is necessary for the health of the mother or her
13 unborn child.

14 (Source: P.A. 100-538, eff. 1-1-18.)

15 Section 15. The Problem Pregnancy Health Services and Care
16 Act is amended by changing Section 4-100 as follows:

17 (410 ILCS 230/4-100) (from Ch. 111 1/2, par. 4604-100)

18 Sec. 4-100. The Department may make grants to nonprofit
19 agencies and organizations which do not use such grants to
20 refer or counsel for, or perform, abortions and which
21 coordinate and establish linkages among services that will
22 further the purposes of this Act and, where appropriate, will
23 provide, supplement, or improve the quality of such services.

24 (Source: P.A. 100-538, eff. 1-1-18.)

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1 Section 20. The Illinois Abortion Law of 1975 is amended by
2 changing Section 1 as follows:

3 (720 ILCS 510/1) (from Ch. 38, par. 81-21)

4 Sec. 1. It is the intention of the General Assembly of the
5 State of Illinois to reasonably regulate abortion in
6 conformance with the ~~legal standards set forth in the decisions~~
7 of the United States Supreme Court of January 22, 1973. Without
8 in any way restricting the right of privacy of a woman or the
9 right of a woman to an abortion under those decisions, the
10 General Assembly of the State of Illinois do solemnly declare
11 and find in reaffirmation of the longstanding policy of this
12 State, that the unborn child is a human being from the time of
13 conception and is, therefore, a legal person for purposes of
14 the unborn child's right to life and is entitled to the right
15 to life from conception under the laws and Constitution of this
16 State. Further, the General Assembly finds and declares that
17 longstanding policy of this State to protect the right to life
18 of the unborn child from conception by prohibiting abortion
19 unless necessary to preserve the life of the mother is
20 impermissible only because of the decisions of the United
21 States Supreme Court and that, therefore, if those decisions of
22 the United States Supreme Court are ever reversed or modified
23 or the United States Constitution is amended to allow
24 protection of the unborn then the former policy of this State

1 to prohibit abortions unless necessary for the preservation of
2 the mother's life shall be reinstated.

3 It is the further intention of the General Assembly to
4 assure and protect the woman's health and the integrity of the
5 woman's decision whether or not to continue to bear a child, to
6 protect the valid and compelling state interest in the infant
7 and unborn child, to assure the integrity of marital and
8 familial relations and the rights and interests of persons who
9 participate in such relations, and to gather data for
10 establishing criteria for medical decisions. The General
11 Assembly finds as fact, upon hearings and public disclosures,
12 that these rights and interests are not secure in the economic
13 and social context in which abortion is presently performed.

14 (Source: P.A. 100-538, eff. 1-1-18.)