SB0144

LRB09504988MJR25055b

95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

SB0144

Introduced 1/31/2007, by Sen. Deanna Demuzio

SYNOPSIS AS INTRODUCED:

215 ILCS 105/7	from Ch. 73, par. 1307
215 ILCS 105/8	from Ch. 73, par. 1308

Amends the Comprehensive Health Insurance Plan Act. Increases the lifetime benefit limitation from $1,500,000 to $2,000,000. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning regulation.

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

4 Section 5. The Comprehensive Health Insurance Plan Act is
5 amended by changing Sections 7 and 8 as follows:

6 (215 ILCS 105/7) (from Ch. 73, par. 1307)
7 Sec. 7. Eligibility.
8 a. Except as provided in subsection (e) of this Section or
9 in Section 15 of this Act, any person who is either a citizen
10 of the United States or an alien lawfully admitted for
11 permanent residence and who has been for a period of at least
12 180 days and continues to be a resident of this State shall be
13 eligible for Plan coverage under this Section if evidence is
14 provided of:
15 (1) A notice of rejection or refusal to issue
16 substantially similar individual health insurance coverage
17 for health reasons by a health insurance issuer; or
18 (2) A refusal by a health insurance issuer to issue
19 individual health insurance coverage except at a rate
20 exceeding the applicable Plan rate for which the person is
21 responsible.
22 A rejection or refusal by a group health plan or health
23 insurance issuer offering only stop-loss or excess of loss

1 insurance or contracts, agreements, or other arrangements for
2 reinsurance coverage with respect to the applicant shall not be
3 sufficient evidence under this subsection.
4 b. The board shall promulgate a list of medical or health
5 conditions for which a person who is either a citizen of the
6 United States or an alien lawfully admitted for permanent
7 residence and a resident of this State would be eligible for
8 Plan coverage without applying for health insurance coverage
9 pursuant to subsection a. of this Section. Persons who can
10 demonstrate the existence or history of any medical or health
11 conditions on the list promulgated by the board shall not be
12 required to provide the evidence specified in subsection a. of
13 this Section. The list shall be effective on the first day of
14 the operation of the Plan and may be amended from time to time
15 as appropriate.
16 c. Family members of the same household who each are
17 covered persons are eligible for optional family coverage under
18 the Plan.
19 d. For persons qualifying for coverage in accordance with
20 Section 7 of this Act, the board shall, if it determines that
21 such appropriations as are made pursuant to Section 12 of this
22 Act are insufficient to allow the board to accept all of the
23 eligible persons which it projects will apply for enrollment
24 under the Plan, limit or close enrollment to ensure that the
25 Plan is not over-subscribed and that it has sufficient
26 resources to meet its obligations to existing enrollees. The

board shall not limit or close enrollment for federally eligible individuals.

e. A person shall not be eligible for coverage under the Plan if:

(1) He or she has or obtains other coverage under a group health plan or health insurance coverage substantially similar to or better than a Plan policy as an insured or covered dependent or would be eligible to have that coverage if he or she elected to obtain it. Persons otherwise eligible for Plan coverage may, however, solely for the purpose of having coverage for a pre-existing condition, maintain other coverage only while satisfying any pre-existing condition waiting period under a Plan policy or a subsequent replacement policy of a Plan policy.

(1.1) His or her prior coverage under a group health plan or health insurance coverage, provided or arranged by an employer of more than 10 employees was discontinued for any reason without the entire group or plan being discontinued and not replaced, provided he or she remains an employee, or dependent thereof, of the same employer.

(2) He or she is a recipient of or is approved to receive medical assistance, except that a person may continue to receive medical assistance through the medical assistance no grant program, but only while satisfying the requirements for a preexisting condition under Section 8, subsection f. of this Act. Payment of premiums pursuant to

this Act shall be allocable to the person's spenddown for purposes of the medical assistance no grant program, but that person shall not be eligible for any Plan benefits while that person remains eligible for medical assistance. If the person continues to receive or be approved to receive medical assistance through the medical assistance no grant program at or after the time that requirements for a preexisting condition are satisfied, the person shall not be eligible for coverage under the Plan. In that circumstance, coverage under the plan shall terminate as of the expiration of the preexisting condition limitation period. Under all other circumstances, coverage under the Plan shall automatically terminate as of the effective date of any medical assistance.

(3) Except as provided in Section 15, the person has previously participated in the Plan and voluntarily terminated Plan coverage, unless 12 months have elapsed since the person's latest voluntary termination of coverage.

(4) The person fails to pay the required premium under the covered person's terms of enrollment and participation, in which event the liability of the Plan shall be limited to benefits incurred under the Plan for the time period for which premiums had been paid and the covered person remained eligible for Plan coverage.

(5) The Plan has paid a total of $2,000,000 ~~$1,500,000~~

in benefits on behalf of the covered person.

(6) The person is a resident of a public institution.

(7) The person's premium is paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of such employee, of a government agency or health care provider or, except when a person's premium is paid by the U.S. Treasury Department pursuant to the federal Trade Act of 2002.

(8) The person has or later receives other benefits or funds from any settlement, judgement, or award resulting from any accident or injury, regardless of the date of the accident or injury, or any other circumstances creating a legal liability for damages due that person by a third party, whether the settlement, judgment, or award is in the form of a contract, agreement, or trust on behalf of a minor or otherwise and whether the settlement, judgment, or award is payable to the person, his or her dependent, estate, personal representative, or guardian in a lump sum or over time, so long as there continues to be benefits or assets remaining from those sources in an amount in excess of $300,000.

(9) Within the 5 years prior to the date a person's Plan application is received by the Board, the person's coverage under any health care benefit program as defined

1 in 18 U.S.C. 24, including any public or private plan or
2 contract under which any medical benefit, item, or service
3 is provided, was terminated as a result of any act or
4 practice that constitutes fraud under State or federal law
5 or as a result of an intentional misrepresentation of
6 material fact; or if that person knowingly and willfully
7 obtained or attempted to obtain, or fraudulently aided or
8 attempted to aid any other person in obtaining, any
9 coverage or benefits under the Plan to which that person
10 was not entitled.
11 f. The board or the administrator shall require
12 verification of residency and may require any additional
13 information or documentation, or statements under oath, when
14 necessary to determine residency upon initial application and
15 for the entire term of the policy.
16 g. Coverage shall cease (i) on the date a person is no
17 longer a resident of Illinois, (ii) on the date a person
18 requests coverage to end, (iii) upon the death of the covered
19 person, (iv) on the date State law requires cancellation of the
20 policy, or (v) at the Plan's option, 30 days after the Plan
21 makes any inquiry concerning a person's eligibility or place of
22 residence to which the person does not reply.
23 h. Except under the conditions set forth in subsection g of
24 this Section, the coverage of any person who ceases to meet the
25 eligibility requirements of this Section shall be terminated at
26 the end of the current policy period for which the necessary

premiums have been paid.
(Source: P.A. 93-33, eff. 6-23-03; 93-34, eff. 6-23-03; 94-17, eff. 1-1-06; 94-737, eff. 5-3-06.)

(215 ILCS 105/8) (from Ch. 73, par. 1308)

Sec. 8. Minimum benefits.

a. Availability. The Plan shall offer in an annually renewable policy major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the Plan shall pay an eligible person's covered expenses, subject to limit on the deductible and coinsurance payments authorized under paragraph (4) of subsection d of this Section, up to a lifetime benefit limit of $2,000,000 ~~$1,500,000~~ per covered individual. The maximum limit under this subsection shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board. Any person who otherwise would qualify for coverage under the Plan, but is excluded because he or she is eligible for Medicare, shall be eligible for any separate Medicare supplement policy or policies which the Board may offer.

b. Outline of benefits. Covered expenses shall be limited to the usual and customary charge, including negotiated fees, in the locality for the following services and articles when prescribed by a physician and determined by the Plan to be medically necessary for the following areas of services, subject to such separate deductibles, co-payments, exclusions,

and other limitations on benefits as the Board shall establish and approve, and the other provisions of this Section:

(1) Hospital services, except that any services provided by a hospital that is located more than 75 miles outside the State of Illinois shall be covered only for a maximum of 45 days in any calendar year. With respect to covered expenses incurred during any calendar year ending on or after December 31, 1999, inpatient hospitalization of an eligible person for the treatment of mental illness at a hospital located within the State of Illinois shall be subject to the same terms and conditions as for any other illness.

(2) Professional services for the diagnosis or treatment of injuries, illnesses or conditions, other than dental and mental and nervous disorders as described in paragraph (17), which are rendered by a physician, or by other licensed professionals at the physician's direction. This includes reconstruction of the breast on which a mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

(2.5) Professional services provided by a physician to children under the age of 16 years for physical examinations and age appropriate immunizations ordered by a physician licensed to practice medicine in all its

branches.

(3) (Blank).

(4) Outpatient prescription drugs that by law require a prescription written by a physician licensed to practice medicine in all its branches subject to such separate deductible, copayment, and other limitations or restrictions as the Board shall approve, including the use of a prescription drug card or any other program, or both.

(5) Skilled nursing services of a licensed skilled nursing facility for not more than 120 days during a policy year.

(6) Services of a home health agency in accord with a home health care plan, up to a maximum of 270 visits per year.

(7) Services of a licensed hospice for not more than 180 days during a policy year.

(8) Use of radium or other radioactive materials.

(9) Oxygen.

(10) Anesthetics.

(11) Orthoses and prostheses other than dental.

(12) Rental or purchase in accordance with Board policies or procedures of durable medical equipment, other than eyeglasses or hearing aids, for which there is no personal use in the absence of the condition for which it is prescribed.

(13) Diagnostic x-rays and laboratory tests.

1 (14) Oral surgery (i) for excision of partially or
2 completely unerupted impacted teeth when not performed in
3 connection with the routine extraction or repair of teeth;
4 (ii) for excision of tumors or cysts of the jaws, cheeks,
5 lips, tongue, and roof and floor of the mouth; (iii)
6 required for correction of cleft lip and palate and other
7 craniofacial and maxillofacial birth defects; or (iv) for
8 treatment of injuries to natural teeth or a fractured jaw
9 due to an accident.

10 (15) Physical, speech, and functional occupational
11 therapy as medically necessary and provided by appropriate
12 licensed professionals.

13 (16) Emergency and other medically necessary
14 transportation provided by a licensed ambulance service to
15 the nearest health care facility qualified to treat a
16 covered illness, injury, or condition, subject to the
17 provisions of the Emergency Medical Systems (EMS) Act.

18 (17) Outpatient services for diagnosis and treatment
19 of mental and nervous disorders provided that a covered
20 person shall be required to make a copayment not to exceed
21 50% and that the Plan's payment shall not exceed such
22 amounts as are established by the Board.

23 (18) Human organ or tissue transplants specified by the
24 Board that are performed at a hospital designated by the
25 Board as a participating transplant center for that
26 specific organ or tissue transplant.

1 (19) Naprapathic services, as appropriate, provided by
2 a licensed naprapathic practitioner.
3 c. Exclusions. Covered expenses of the Plan shall not
4 include the following:
5 (1) Any charge for treatment for cosmetic purposes
6 other than for reconstructive surgery when the service is
7 incidental to or follows surgery resulting from injury,
8 sickness or other diseases of the involved part or surgery
9 for the repair or treatment of a congenital bodily defect
10 to restore normal bodily functions.
11 (2) Any charge for care that is primarily for rest,
12 custodial, educational, or domiciliary purposes.
13 (3) Any charge for services in a private room to the
14 extent it is in excess of the institution's charge for its
15 most common semiprivate room, unless a private room is
16 prescribed as medically necessary by a physician.
17 (4) That part of any charge for room and board or for
18 services rendered or articles prescribed by a physician,
19 dentist, or other health care personnel that exceeds the
20 reasonable and customary charge in the locality or for any
21 services or supplies not medically necessary for the
22 diagnosed injury or illness.
23 (5) Any charge for services or articles the provision
24 of which is not within the scope of licensure of the
25 institution or individual providing the services or
26 articles.

1 (6) Any expense incurred prior to the effective date of
2 coverage by the Plan for the person on whose behalf the
3 expense is incurred.
4 (7) Dental care, dental surgery, dental treatment, any
5 other dental procedure involving the teeth or
6 periodontium, or any dental appliances, including crowns,
7 bridges, implants, or partial or complete dentures, except
8 as specifically provided in paragraph (14) of subsection b
9 of this Section.
10 (8) Eyeglasses, contact lenses, hearing aids or their
11 fitting.
12 (9) Illness or injury due to acts of war.
13 (10) Services of blood donors and any fee for failure
14 to replace the first 3 pints of blood provided to a covered
15 person each policy year.
16 (11) Personal supplies or services provided by a
17 hospital or nursing home, or any other nonmedical or
18 nonprescribed supply or service.
19 (12) Routine maternity charges for a pregnancy, except
20 where added as optional coverage with payment of an
21 additional premium for pregnancy resulting from conception
22 occurring after the effective date of the optional
23 coverage.
24 (13) (Blank).
25 (14) Any expense or charge for services, drugs, or
26 supplies that are: (i) not provided in accord with

1 generally accepted standards of current medical practice;
2 (ii) for procedures, treatments, equipment, transplants,
3 or implants, any of which are investigational,
4 experimental, or for research purposes; (iii)
5 investigative and not proven safe and effective; or (iv)
6 for, or resulting from, a gender transformation operation.
7 (15) Any expense or charge for routine physical
8 examinations or tests except as provided in item (2.5) of
9 subsection b of this Section.
10 (16) Any expense for which a charge is not made in the
11 absence of insurance or for which there is no legal
12 obligation on the part of the patient to pay.
13 (17) Any expense incurred for benefits provided under
14 the laws of the United States and this State, including
15 Medicare, Medicaid, and other medical assistance, maternal
16 and child health services and any other program that is
17 administered or funded by the Department of Human Services,
18 Department of Healthcare and Family Services, or
19 Department of Public Health, military service-connected
20 disability payments, medical services provided for members
21 of the armed forces and their dependents or employees of
22 the armed forces of the United States, and medical services
23 financed on behalf of all citizens by the United States.
24 (18) Any expense or charge for in vitro fertilization,
25 artificial insemination, or any other artificial means
26 used to cause pregnancy.

(19) Any expense or charge for oral contraceptives used for birth control or any other temporary birth control measures.

(20) Any expense or charge for sterilization or sterilization reversals.

(21) Any expense or charge for weight loss programs, exercise equipment, or treatment of obesity, except when certified by a physician as morbid obesity (at least 2 times normal body weight).

(22) Any expense or charge for acupuncture treatment unless used as an anesthetic agent for a covered surgery.

(23) Any expense or charge for or related to organ or tissue transplants other than those performed at a hospital with a Board approved organ transplant program that has been designated by the Board as a preferred or exclusive provider organization for that specific organ or tissue transplant.

(24) Any expense or charge for procedures, treatments, equipment, or services that are provided in special settings for research purposes or in a controlled environment, are being studied for safety, efficiency, and effectiveness, and are awaiting endorsement by the appropriate national medical speciality college for general use within the medical community.

d. Deductibles and coinsurance.

The Plan coverage defined in Section 6 shall provide for a

1 choice of deductibles per individual as authorized by the
2 Board. If 2 individual members of the same family household,
3 who are both covered persons under the Plan, satisfy the same
4 applicable deductibles, no other member of that family who is
5 also a covered person under the Plan shall be required to meet
6 any deductibles for the balance of that calendar year. The
7 deductibles must be applied first to the authorized amount of
8 covered expenses incurred by the covered person. A mandatory
9 coinsurance requirement shall be imposed at the rate authorized
10 by the Board in excess of the mandatory deductible, the
11 coinsurance in the aggregate not to exceed such amounts as are
12 authorized by the Board per annum. At its discretion the Board
13 may, however, offer catastrophic coverages or other policies
14 that provide for larger deductibles with or without coinsurance
15 requirements. The deductibles and coinsurance factors may be
16 adjusted annually according to the Medical Component of the
17 Consumer Price Index.

18 e. Scope of coverage.

19 (1) In approving any of the benefit plans to be offered
20 by the Plan, the Board shall establish such benefit levels,
21 deductibles, coinsurance factors, exclusions, and
22 limitations as it may deem appropriate and that it believes
23 to be generally reflective of and commensurate with health
24 insurance coverage that is provided in the individual
25 market in this State.

26 (2) The benefit plans approved by the Board may also

1 provide for and employ various cost containment measures
2 and other requirements including, but not limited to,
3 preadmission certification, prior approval, second
4 surgical opinions, concurrent utilization review programs,
5 individual case management, preferred provider
6 organizations, health maintenance organizations, and other
7 cost effective arrangements for paying for covered
8 expenses.
9 f. Preexisting conditions.
10 (1) Except for federally eligible individuals
11 qualifying for Plan coverage under Section 15 of this Act
12 or eligible persons who qualify for the waiver authorized
13 in paragraph (3) of this subsection, plan coverage shall
14 exclude charges or expenses incurred during the first 6
15 months following the effective date of coverage as to any
16 condition for which medical advice, care or treatment was
17 recommended or received during the 6 month period
18 immediately preceding the effective date of coverage.
19 (2) (Blank).
20 (3) Waiver: The preexisting condition exclusions as
21 set forth in paragraph (1) of this subsection shall be
22 waived to the extent to which the eligible person (a) has
23 satisfied similar exclusions under any prior individual
24 health insurance policy that was involuntarily terminated
25 because of the insolvency of the issuer of the policy and
26 (b) has applied for Plan coverage within 90 days following

1 the involuntary termination of that individual health
2 insurance coverage.
3 g. Other sources primary; nonduplication of benefits.
4 (1) The Plan shall be the last payor of benefits
5 whenever any other benefit or source of third party payment
6 is available. Subject to the provisions of subsection e of
7 Section 7, benefits otherwise payable under Plan coverage
8 shall be reduced by all amounts paid or payable by Medicare
9 or any other government program or through any health
10 insurance coverage or group health plan, whether by
11 insurance, reimbursement, or otherwise, or through any
12 third party liability, settlement, judgment, or award,
13 regardless of the date of the settlement, judgment, or
14 award, whether the settlement, judgment, or award is in the
15 form of a contract, agreement, or trust on behalf of a
16 minor or otherwise and whether the settlement, judgment, or
17 award is payable to the covered person, his or her
18 dependent, estate, personal representative, or guardian in
19 a lump sum or over time, and by all hospital or medical
20 expense benefits paid or payable under any worker's
21 compensation coverage, automobile medical payment, or
22 liability insurance, whether provided on the basis of fault
23 or nonfault, and by any hospital or medical benefits paid
24 or payable under or provided pursuant to any State or
25 federal law or program.
26 (2) The Plan shall have a cause of action against any

1 covered person or any other person or entity for the
2 recovery of any amount paid to the extent the amount was
3 for treatment, services, or supplies not covered in this
4 Section or in excess of benefits as set forth in this
5 Section.
6 (3) Whenever benefits are due from the Plan because of
7 sickness or an injury to a covered person resulting from a
8 third party's wrongful act or negligence and the covered
9 person has recovered or may recover damages from a third
10 party or its insurer, the Plan shall have the right to
11 reduce benefits or to refuse to pay benefits that otherwise
12 may be payable by the amount of damages that the covered
13 person has recovered or may recover regardless of the date
14 of the sickness or injury or the date of any settlement,
15 judgment, or award resulting from that sickness or injury.
16 During the pendency of any action or claim that is
17 brought by or on behalf of a covered person against a third
18 party or its insurer, any benefits that would otherwise be
19 payable except for the provisions of this paragraph (3)
20 shall be paid if payment by or for the third party has not
21 yet been made and the covered person or, if incapable, that
22 person's legal representative agrees in writing to pay back
23 promptly the benefits paid as a result of the sickness or
24 injury to the extent of any future payments made by or for
25 the third party for the sickness or injury. This agreement
26 is to apply whether or not liability for the payments is

1 established or admitted by the third party or whether those
2 payments are itemized.
3 Any amounts due the plan to repay benefits may be
4 deducted from other benefits payable by the Plan after
5 payments by or for the third party are made.
6 (4) Benefits due from the Plan may be reduced or
7 refused as an offset against any amount otherwise
8 recoverable under this Section.
9 h. Right of subrogation; recoveries.
10 (1) Whenever the Plan has paid benefits because of
11 sickness or an injury to any covered person resulting from
12 a third party's wrongful act or negligence, or for which an
13 insurer is liable in accordance with the provisions of any
14 policy of insurance, and the covered person has recovered
15 or may recover damages from a third party that is liable
16 for the damages, the Plan shall have the right to recover
17 the benefits it paid from any amounts that the covered
18 person has received or may receive regardless of the date
19 of the sickness or injury or the date of any settlement,
20 judgment, or award resulting from that sickness or injury.
21 The Plan shall be subrogated to any right of recovery the
22 covered person may have under the terms of any private or
23 public health care coverage or liability coverage,
24 including coverage under the Workers' Compensation Act or
25 the Workers' Occupational Diseases Act, without the
26 necessity of assignment of claim or other authorization to

1 secure the right of recovery. To enforce its subrogation
2 right, the Plan may (i) intervene or join in an action or
3 proceeding brought by the covered person or his personal
4 representative, including his guardian, conservator,
5 estate, dependents, or survivors, against any third party
6 or the third party's insurer that may be liable or (ii)
7 institute and prosecute legal proceedings against any
8 third party or the third party's insurer that may be liable
9 for the sickness or injury in an appropriate court either
10 in the name of the Plan or in the name of the covered
11 person or his personal representative, including his
12 guardian, conservator, estate, dependents, or survivors.
13 (2) If any action or claim is brought by or on behalf
14 of a covered person against a third party or the third
15 party's insurer, the covered person or his personal
16 representative, including his guardian, conservator,
17 estate, dependents, or survivors, shall notify the Plan by
18 personal service or registered mail of the action or claim
19 and of the name of the court in which the action or claim
20 is brought, filing proof thereof in the action or claim.
21 The Plan may, at any time thereafter, join in the action or
22 claim upon its motion so that all orders of court after
23 hearing and judgment shall be made for its protection. No
24 release or settlement of a claim for damages and no
25 satisfaction of judgment in the action shall be valid
26 without the written consent of the Plan to the extent of

1 its interest in the settlement or judgment and of the
2 covered person or his personal representative.
3 (3) In the event that the covered person or his
4 personal representative fails to institute a proceeding
5 against any appropriate third party before the fifth month
6 before the action would be barred, the Plan may, in its own
7 name or in the name of the covered person or personal
8 representative, commence a proceeding against any
9 appropriate third party for the recovery of damages on
10 account of any sickness, injury, or death to the covered
11 person. The covered person shall cooperate in doing what is
12 reasonably necessary to assist the Plan in any recovery and
13 shall not take any action that would prejudice the Plan's
14 right to recovery. The Plan shall pay to the covered person
15 or his personal representative all sums collected from any
16 third party by judgment or otherwise in excess of amounts
17 paid in benefits under the Plan and amounts paid or to be
18 paid as costs, attorneys fees, and reasonable expenses
19 incurred by the Plan in making the collection or enforcing
20 the judgment.
21 (4) In the event that a covered person or his personal
22 representative, including his guardian, conservator,
23 estate, dependents, or survivors, recovers damages from a
24 third party for sickness or injury caused to the covered
25 person, the covered person or the personal representative
26 shall pay to the Plan from the damages recovered the amount

1 of benefits paid or to be paid on behalf of the covered
2 person.
3 (5) When the action or claim is brought by the covered
4 person alone and the covered person incurs a personal
5 liability to pay attorney's fees and costs of litigation,
6 the Plan's claim for reimbursement of the benefits provided
7 to the covered person shall be the full amount of benefits
8 paid to or on behalf of the covered person under this Act
9 less a pro rata share that represents the Plan's reasonable
10 share of attorney's fees paid by the covered person and
11 that portion of the cost of litigation expenses determined
12 by multiplying by the ratio of the full amount of the
13 expenditures to the full amount of the judgement, award, or
14 settlement.
15 (6) In the event of judgment or award in a suit or
16 claim against a third party or insurer, the court shall
17 first order paid from any judgement or award the reasonable
18 litigation expenses incurred in preparation and
19 prosecution of the action or claim, together with
20 reasonable attorney's fees. After payment of those
21 expenses and attorney's fees, the court shall apply out of
22 the balance of the judgment or award an amount sufficient
23 to reimburse the Plan the full amount of benefits paid on
24 behalf of the covered person under this Act, provided the
25 court may reduce and apportion the Plan's portion of the
26 judgement proportionate to the recovery of the covered

person. The burden of producing evidence sufficient to support the exercise by the court of its discretion to reduce the amount of a proven charge sought to be enforced against the recovery shall rest with the party seeking the reduction. The court may consider the nature and extent of the injury, economic and non-economic loss, settlement offers, comparative negligence as it applies to the case at hand, hospital costs, physician costs, and all other appropriate costs. The Plan shall pay its pro rata share of the attorney fees based on the Plan's recovery as it compares to the total judgment. Any reimbursement rights of the Plan shall take priority over all other liens and charges existing under the laws of this State with the exception of any attorney liens filed under the Attorneys Lien Act.

(7) The Plan may compromise or settle and release any claim for benefits provided under this Act or waive any claims for benefits, in whole or in part, for the convenience of the Plan or if the Plan determines that collection would result in undue hardship upon the covered person.

(Source: P.A. 94-737, eff. 5-3-06.)

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