Insurance Committee

Filed: 5/8/2007

1 AMENDMENT TO SENATE BILL 144

2 AMENDMENT NO. ______. Amend Senate Bill 144 by replacing
3 everything after the enacting clause with the following:

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

1 for health reasons by a health insurance issuer; or
2 (2) A refusal by a health insurance issuer to issue
3 individual health insurance coverage except at a rate
4 exceeding the applicable Plan rate for which the person is
5 responsible.
6 A rejection or refusal by a group health plan or health
7 insurance issuer offering only stop-loss or excess of loss
8 insurance or contracts, agreements, or other arrangements for
9 reinsurance coverage with respect to the applicant shall not be
10 sufficient evidence under this subsection.
11 b. The board shall promulgate a list of medical or health
12 conditions for which a person who is either a citizen of the
13 United States or an alien lawfully admitted for permanent
14 residence and a resident of this State would be eligible for
15 Plan coverage without applying for health insurance coverage
16 pursuant to subsection a. of this Section. Persons who can
17 demonstrate the existence or history of any medical or health
18 conditions on the list promulgated by the board shall not be
19 required to provide the evidence specified in subsection a. of
20 this Section. The list shall be effective on the first day of
21 the operation of the Plan and may be amended from time to time
22 as appropriate.
23 c. Family members of the same household who each are
24 covered persons are eligible for optional family coverage under
25 the Plan.
26 d. For persons qualifying for coverage in accordance with

1 Section 7 of this Act, the board shall, if it determines that
2 such appropriations as are made pursuant to Section 12 of this
3 Act are insufficient to allow the board to accept all of the
4 eligible persons which it projects will apply for enrollment
5 under the Plan, limit or close enrollment to ensure that the
6 Plan is not over-subscribed and that it has sufficient
7 resources to meet its obligations to existing enrollees. The
8 board shall not limit or close enrollment for federally
9 eligible individuals.

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

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

22 (1.1) His or her prior coverage under a group health
23 plan or health insurance coverage, provided or arranged by
24 an employer of more than 10 employees was discontinued for
25 any reason without the entire group or plan being
26 discontinued and not replaced, provided he or she remains

1 an employee, or dependent thereof, of the same employer.

2 (2) He or she is a recipient of or is approved to
3 receive medical assistance, except that a person may
4 continue to receive medical assistance through the medical
5 assistance no grant program, but only while satisfying the
6 requirements for a preexisting condition under Section 8,
7 subsection f. of this Act. Payment of premiums pursuant to
8 this Act shall be allocable to the person's spenddown for
9 purposes of the medical assistance no grant program, but
10 that person shall not be eligible for any Plan benefits
11 while that person remains eligible for medical assistance.
12 If the person continues to receive or be approved to
13 receive medical assistance through the medical assistance
14 no grant program at or after the time that requirements for
15 a preexisting condition are satisfied, the person shall not
16 be eligible for coverage under the Plan. In that
17 circumstance, coverage under the plan shall terminate as of
18 the expiration of the preexisting condition limitation
19 period. Under all other circumstances, coverage under the
20 Plan shall automatically terminate as of the effective date
21 of any medical assistance.

22 (3) Except as provided in Section 15, the person has
23 previously participated in the Plan and voluntarily
24 terminated Plan coverage, unless 12 months have elapsed
25 since the person's latest voluntary termination of
26 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 (i) until 3 years after the effective date of this amendatory Act of the 95th General Assembly has paid a total of $2,000,000 ~~$1,500,000~~ in benefits on behalf of the covered person or (ii) 3 years or more after the effective date of this amendatory Act of the 95th General Assembly has paid a total of $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

1 legal liability for damages due that person by a third
2 party, whether the settlement, judgment, or award is in the
3 form of a contract, agreement, or trust on behalf of a
4 minor or otherwise and whether the settlement, judgment, or
5 award is payable to the person, his or her dependent,
6 estate, personal representative, or guardian in a lump sum
7 or over time, so long as there continues to be benefits or
8 assets remaining from those sources in an amount in excess
9 of $300,000.

10 (9) Within the 5 years prior to the date a person's
11 Plan application is received by the Board, the person's
12 coverage under any health care benefit program as defined
13 in 18 U.S.C. 24, including any public or private plan or
14 contract under which any medical benefit, item, or service
15 is provided, was terminated as a result of any act or
16 practice that constitutes fraud under State or federal law
17 or as a result of an intentional misrepresentation of
18 material fact; or if that person knowingly and willfully
19 obtained or attempted to obtain, or fraudulently aided or
20 attempted to aid any other person in obtaining, any
21 coverage or benefits under the Plan to which that person
22 was not entitled.

23 f. The board or the administrator shall require
24 verification of residency and may require any additional
25 information or documentation, or statements under oath, when
26 necessary to determine residency upon initial application and

1 for the entire term of the policy.
2 g. Coverage shall cease (i) on the date a person is no
3 longer a resident of Illinois, (ii) on the date a person
4 requests coverage to end, (iii) upon the death of the covered
5 person, (iv) on the date State law requires cancellation of the
6 policy, or (v) at the Plan's option, 30 days after the Plan
7 makes any inquiry concerning a person's eligibility or place of
8 residence to which the person does not reply.
9 h. Except under the conditions set forth in subsection g of
10 this Section, the coverage of any person who ceases to meet the
11 eligibility requirements of this Section shall be terminated at
12 the end of the current policy period for which the necessary
13 premiums have been paid.
14 (Source: P.A. 93-33, eff. 6-23-03; 93-34, eff. 6-23-03; 94-17,
15 eff. 1-1-06; 94-737, eff. 5-3-06.)

16 (215 ILCS 105/8) (from Ch. 73, par. 1308)
17 Sec. 8. Minimum benefits.
18 a. Availability. The Plan shall offer in an annually
19 renewable policy major medical expense coverage to every
20 eligible person who is not eligible for Medicare. Major medical
21 expense coverage offered by the Plan shall pay an eligible
22 person's covered expenses, subject to limit on the deductible
23 and coinsurance payments authorized under paragraph (4) of
24 subsection d of this Section, up to a lifetime benefit limit of
25 $2,000,000 until 3 years after the effective date of this

1 amendatory Act of the 95th General Assembly, and $1,500,000 in
2 benefits 3 years or more after the effective date of this
3 amendatory Act of the 95th General Assembly per covered
4 individual. The maximum limit under this subsection shall not
5 be altered by the Board, and no actuarial equivalent benefit
6 may be substituted by the Board. Any person who otherwise would
7 qualify for coverage under the Plan, but is excluded because he
8 or she is eligible for Medicare, shall be eligible for any
9 separate Medicare supplement policy or policies which the Board
10 may offer.

11 b. Outline of benefits. Covered expenses shall be limited
12 to the usual and customary charge, including negotiated fees,
13 in the locality for the following services and articles when
14 prescribed by a physician and determined by the Plan to be
15 medically necessary for the following areas of services,
16 subject to such separate deductibles, co-payments, exclusions,
17 and other limitations on benefits as the Board shall establish
18 and approve, and the other provisions of this Section:

19 (1) Hospital services, except that any services
20 provided by a hospital that is located more than 75 miles
21 outside the State of Illinois shall be covered only for a
22 maximum of 45 days in any calendar year. With respect to
23 covered expenses incurred during any calendar year ending
24 on or after December 31, 1999, inpatient hospitalization of
25 an eligible person for the treatment of mental illness at a
26 hospital located within the State of Illinois shall be

1 subject to the same terms and conditions as for any other
2 illness.
3 (2) Professional services for the diagnosis or
4 treatment of injuries, illnesses or conditions, other than
5 dental and mental and nervous disorders as described in
6 paragraph (17), which are rendered by a physician, or by
7 other licensed professionals at the physician's direction.
8 This includes reconstruction of the breast on which a
9 mastectomy was performed; surgery and reconstruction of
10 the other breast to produce a symmetrical appearance; and
11 prostheses and treatment of physical complications at all
12 stages of the mastectomy, including lymphedemas.
13 (2.5) Professional services provided by a physician to
14 children under the age of 16 years for physical
15 examinations and age appropriate immunizations ordered by
16 a physician licensed to practice medicine in all its
17 branches.
18 (3) (Blank).
19 (4) Outpatient prescription drugs that by law require a
20 prescription written by a physician licensed to practice
21 medicine in all its branches subject to such separate
22 deductible, copayment, and other limitations or
23 restrictions as the Board shall approve, including the use
24 of a prescription drug card or any other program, or both.
25 (5) Skilled nursing services of a licensed skilled
26 nursing facility for not more than 120 days during a policy

1 year.

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

5 (7) Services of a licensed hospice for not more than
6 180 days during a policy year.

7 (8) Use of radium or other radioactive materials.

8 (9) Oxygen.

9 (10) Anesthetics.

10 (11) Orthoses and prostheses other than dental.

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

16 (13) Diagnostic x-rays and laboratory tests.

17 (14) Oral surgery (i) for excision of partially or
18 completely unerupted impacted teeth when not performed in
19 connection with the routine extraction or repair of teeth;
20 (ii) for excision of tumors or cysts of the jaws, cheeks,
21 lips, tongue, and roof and floor of the mouth; (iii)
22 required for correction of cleft lip and palate and other
23 craniofacial and maxillofacial birth defects; or (iv) for
24 treatment of injuries to natural teeth or a fractured jaw
25 due to an accident.

26 (15) Physical, speech, and functional occupational

1 therapy as medically necessary and provided by appropriate
2 licensed professionals.
3 (16) Emergency and other medically necessary
4 transportation provided by a licensed ambulance service to
5 the nearest health care facility qualified to treat a
6 covered illness, injury, or condition, subject to the
7 provisions of the Emergency Medical Systems (EMS) Act.
8 (17) Outpatient services for diagnosis and treatment
9 of mental and nervous disorders provided that a covered
10 person shall be required to make a copayment not to exceed
11 50% and that the Plan's payment shall not exceed such
12 amounts as are established by the Board.
13 (18) Human organ or tissue transplants specified by the
14 Board that are performed at a hospital designated by the
15 Board as a participating transplant center for that
16 specific organ or tissue transplant.
17 (19) Naprapathic services, as appropriate, provided by
18 a licensed naprapathic practitioner.
19 c. Exclusions. Covered expenses of the Plan shall not
20 include the following:
21 (1) Any charge for treatment for cosmetic purposes
22 other than for reconstructive surgery when the service is
23 incidental to or follows surgery resulting from injury,
24 sickness or other diseases of the involved part or surgery
25 for the repair or treatment of a congenital bodily defect
26 to restore normal bodily functions.

1 (2) Any charge for care that is primarily for rest,
2 custodial, educational, or domiciliary purposes.
3 (3) Any charge for services in a private room to the
4 extent it is in excess of the institution's charge for its
5 most common semiprivate room, unless a private room is
6 prescribed as medically necessary by a physician.
7 (4) That part of any charge for room and board or for
8 services rendered or articles prescribed by a physician,
9 dentist, or other health care personnel that exceeds the
10 reasonable and customary charge in the locality or for any
11 services or supplies not medically necessary for the
12 diagnosed injury or illness.
13 (5) Any charge for services or articles the provision
14 of which is not within the scope of licensure of the
15 institution or individual providing the services or
16 articles.
17 (6) Any expense incurred prior to the effective date of
18 coverage by the Plan for the person on whose behalf the
19 expense is incurred.
20 (7) Dental care, dental surgery, dental treatment, any
21 other dental procedure involving the teeth or
22 periodontium, or any dental appliances, including crowns,
23 bridges, implants, or partial or complete dentures, except
24 as specifically provided in paragraph (14) of subsection b
25 of this Section.
26 (8) Eyeglasses, contact lenses, hearing aids or their

1 fitting.
2 (9) Illness or injury due to acts of war.
3 (10) Services of blood donors and any fee for failure
4 to replace the first 3 pints of blood provided to a covered
5 person each policy year.
6 (11) Personal supplies or services provided by a
7 hospital or nursing home, or any other nonmedical or
8 nonprescribed supply or service.
9 (12) Routine maternity charges for a pregnancy, except
10 where added as optional coverage with payment of an
11 additional premium for pregnancy resulting from conception
12 occurring after the effective date of the optional
13 coverage.
14 (13) (Blank).
15 (14) Any expense or charge for services, drugs, or
16 supplies that are: (i) not provided in accord with
17 generally accepted standards of current medical practice;
18 (ii) for procedures, treatments, equipment, transplants,
19 or implants, any of which are investigational,
20 experimental, or for research purposes; (iii)
21 investigative and not proven safe and effective; or (iv)
22 for, or resulting from, a gender transformation operation.
23 (15) Any expense or charge for routine physical
24 examinations or tests except as provided in item (2.5) of
25 subsection b of this Section.
26 (16) Any expense for which a charge is not made in the

1 absence of insurance or for which there is no legal
2 obligation on the part of the patient to pay.
3 (17) Any expense incurred for benefits provided under
4 the laws of the United States and this State, including
5 Medicare, Medicaid, and other medical assistance, maternal
6 and child health services and any other program that is
7 administered or funded by the Department of Human Services,
8 Department of Healthcare and Family Services, or
9 Department of Public Health, military service-connected
10 disability payments, medical services provided for members
11 of the armed forces and their dependents or employees of
12 the armed forces of the United States, and medical services
13 financed on behalf of all citizens by the United States.
14 (18) Any expense or charge for in vitro fertilization,
15 artificial insemination, or any other artificial means
16 used to cause pregnancy.
17 (19) Any expense or charge for oral contraceptives used
18 for birth control or any other temporary birth control
19 measures.
20 (20) Any expense or charge for sterilization or
21 sterilization reversals.
22 (21) Any expense or charge for weight loss programs,
23 exercise equipment, or treatment of obesity, except when
24 certified by a physician as morbid obesity (at least 2
25 times normal body weight).
26 (22) Any expense or charge for acupuncture treatment

1 unless used as an anesthetic agent for a covered surgery.
2 (23) Any expense or charge for or related to organ or
3 tissue transplants other than those performed at a hospital
4 with a Board approved organ transplant program that has
5 been designated by the Board as a preferred or exclusive
6 provider organization for that specific organ or tissue
7 transplant.
8 (24) Any expense or charge for procedures, treatments,
9 equipment, or services that are provided in special
10 settings for research purposes or in a controlled
11 environment, are being studied for safety, efficiency, and
12 effectiveness, and are awaiting endorsement by the
13 appropriate national medical speciality college for
14 general use within the medical community.
15 d. Deductibles and coinsurance.
16 The Plan coverage defined in Section 6 shall provide for a
17 choice of deductibles per individual as authorized by the
18 Board. If 2 individual members of the same family household,
19 who are both covered persons under the Plan, satisfy the same
20 applicable deductibles, no other member of that family who is
21 also a covered person under the Plan shall be required to meet
22 any deductibles for the balance of that calendar year. The
23 deductibles must be applied first to the authorized amount of
24 covered expenses incurred by the covered person. A mandatory
25 coinsurance requirement shall be imposed at the rate authorized
26 by the Board in excess of the mandatory deductible, the

coinsurance in the aggregate not to exceed such amounts as are authorized by the Board per annum. At its discretion the Board may, however, offer catastrophic coverages or other policies that provide for larger deductibles with or without coinsurance requirements. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

e. Scope of coverage.

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

(2) The benefit plans approved by the Board may also provide for and employ various cost containment measures and other requirements including, but not limited to, preadmission certification, prior approval, second surgical opinions, concurrent utilization review programs, individual case management, preferred provider organizations, health maintenance organizations, and other cost effective arrangements for paying for covered expenses.

f. Preexisting conditions.

(1) Except for federally eligible individuals

qualifying for Plan coverage under Section 15 of this Act or eligible persons who qualify for the waiver authorized in paragraph (3) of this subsection, plan coverage shall exclude charges or expenses incurred during the first 6 months following the effective date of coverage as to any condition for which medical advice, care or treatment was recommended or received during the 6 month period immediately preceding the effective date of coverage.

(2) (Blank).

(3) Waiver: The preexisting condition exclusions as set forth in paragraph (1) of this subsection shall be waived to the extent to which the eligible person (a) has satisfied similar exclusions under any prior individual health insurance policy that was involuntarily terminated because of the insolvency of the issuer of the policy and (b) has applied for Plan coverage within 90 days following the involuntary termination of that individual health insurance coverage.

g. Other sources primary; nonduplication of benefits.

(1) The Plan shall be the last payor of benefits whenever any other benefit or source of third party payment is available. Subject to the provisions of subsection e of Section 7, benefits otherwise payable under Plan coverage shall be reduced by all amounts paid or payable by Medicare or any other government program or through any health insurance coverage or group health plan, whether by

1 insurance, reimbursement, or otherwise, or through any
2 third party liability, settlement, judgment, or award,
3 regardless of the date of the settlement, judgment, or
4 award, whether the settlement, judgment, or award is in the
5 form of a contract, agreement, or trust on behalf of a
6 minor or otherwise and whether the settlement, judgment, or
7 award is payable to the covered person, his or her
8 dependent, estate, personal representative, or guardian in
9 a lump sum or over time, and by all hospital or medical
10 expense benefits paid or payable under any worker's
11 compensation coverage, automobile medical payment, or
12 liability insurance, whether provided on the basis of fault
13 or nonfault, and by any hospital or medical benefits paid
14 or payable under or provided pursuant to any State or
15 federal law or program.
16 (2) The Plan shall have a cause of action against any
17 covered person or any other person or entity for the
18 recovery of any amount paid to the extent the amount was
19 for treatment, services, or supplies not covered in this
20 Section or in excess of benefits as set forth in this
21 Section.
22 (3) Whenever benefits are due from the Plan because of
23 sickness or an injury to a covered person resulting from a
24 third party's wrongful act or negligence and the covered
25 person has recovered or may recover damages from a third
26 party or its insurer, the Plan shall have the right to

1 reduce benefits or to refuse to pay benefits that otherwise
2 may be payable by the amount of damages that the covered
3 person has recovered or may recover regardless of the date
4 of the sickness or injury or the date of any settlement,
5 judgment, or award resulting from that sickness or injury.
6 During the pendency of any action or claim that is
7 brought by or on behalf of a covered person against a third
8 party or its insurer, any benefits that would otherwise be
9 payable except for the provisions of this paragraph (3)
10 shall be paid if payment by or for the third party has not
11 yet been made and the covered person or, if incapable, that
12 person's legal representative agrees in writing to pay back
13 promptly the benefits paid as a result of the sickness or
14 injury to the extent of any future payments made by or for
15 the third party for the sickness or injury. This agreement
16 is to apply whether or not liability for the payments is
17 established or admitted by the third party or whether those
18 payments are itemized.
19 Any amounts due the plan to repay benefits may be
20 deducted from other benefits payable by the Plan after
21 payments by or for the third party are made.
22 (4) Benefits due from the Plan may be reduced or
23 refused as an offset against any amount otherwise
24 recoverable under this Section.
25 h. Right of subrogation; recoveries.
26 (1) Whenever the Plan has paid benefits because of

1 sickness or an injury to any covered person resulting from
2 a third party's wrongful act or negligence, or for which an
3 insurer is liable in accordance with the provisions of any
4 policy of insurance, and the covered person has recovered
5 or may recover damages from a third party that is liable
6 for the damages, the Plan shall have the right to recover
7 the benefits it paid from any amounts that the covered
8 person has received or may receive regardless of the date
9 of the sickness or injury or the date of any settlement,
10 judgment, or award resulting from that sickness or injury.
11 The Plan shall be subrogated to any right of recovery the
12 covered person may have under the terms of any private or
13 public health care coverage or liability coverage,
14 including coverage under the Workers' Compensation Act or
15 the Workers' Occupational Diseases Act, without the
16 necessity of assignment of claim or other authorization to
17 secure the right of recovery. To enforce its subrogation
18 right, the Plan may (i) intervene or join in an action or
19 proceeding brought by the covered person or his personal
20 representative, including his guardian, conservator,
21 estate, dependents, or survivors, against any third party
22 or the third party's insurer that may be liable or (ii)
23 institute and prosecute legal proceedings against any
24 third party or the third party's insurer that may be liable
25 for the sickness or injury in an appropriate court either
26 in the name of the Plan or in the name of the covered

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

1 person. The covered person shall cooperate in doing what is
2 reasonably necessary to assist the Plan in any recovery and
3 shall not take any action that would prejudice the Plan's
4 right to recovery. The Plan shall pay to the covered person
5 or his personal representative all sums collected from any
6 third party by judgment or otherwise in excess of amounts
7 paid in benefits under the Plan and amounts paid or to be
8 paid as costs, attorneys fees, and reasonable expenses
9 incurred by the Plan in making the collection or enforcing
10 the judgment.

11 (4) In the event that a covered person or his personal
12 representative, including his guardian, conservator,
13 estate, dependents, or survivors, recovers damages from a
14 third party for sickness or injury caused to the covered
15 person, the covered person or the personal representative
16 shall pay to the Plan from the damages recovered the amount
17 of benefits paid or to be paid on behalf of the covered
18 person.

19 (5) When the action or claim is brought by the covered
20 person alone and the covered person incurs a personal
21 liability to pay attorney's fees and costs of litigation,
22 the Plan's claim for reimbursement of the benefits provided
23 to the covered person shall be the full amount of benefits
24 paid to or on behalf of the covered person under this Act
25 less a pro rata share that represents the Plan's reasonable
26 share of attorney's fees paid by the covered person and

that portion of the cost of litigation expenses determined by multiplying by the ratio of the full amount of the expenditures to the full amount of the judgement, award, or settlement.

(6) In the event of judgment or award in a suit or claim against a third party or insurer, the court shall first order paid from any judgement or award the reasonable litigation expenses incurred in preparation and prosecution of the action or claim, together with reasonable attorney's fees. After payment of those expenses and attorney's fees, the court shall apply out of the balance of the judgment or award an amount sufficient to reimburse the Plan the full amount of benefits paid on behalf of the covered person under this Act, provided the court may reduce and apportion the Plan's portion of the 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

1 compares to the total judgment. Any reimbursement rights of
2 the Plan shall take priority over all other liens and
3 charges existing under the laws of this State with the
4 exception of any attorney liens filed under the Attorneys
5 Lien Act.
6 (7) The Plan may compromise or settle and release any
7 claim for benefits provided under this Act or waive any
8 claims for benefits, in whole or in part, for the
9 convenience of the Plan or if the Plan determines that
10 collection would result in undue hardship upon the covered
11 person.
12 (Source: P.A. 94-737, eff. 5-3-06.)

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