Report From Agency

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE CREATING A RULE

To create s. Ins 3.33, Wis. Adm. Code, relating to uniform questions and format for individual health insurance.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. Statutes interpreted:

ss. 600.01, 628.34 (12), 601.41 (10), Stats.

2. Statutory authority:

ss. 601.41 (3), 601.41 (10), Stats.

3. Explanation of the OCI's authority to promulgate the proposed rule under these statutes:

In accordance with s. 601.41 (10), Stats., the commissioner is required to prescribe by rule uniform questions and format of an application that is to be exclusively used by insurers authorized to offer individual major medical health insurance coverage. Further the commissioner has rule-making authority pursuant to s. 601.41 (3), Stats.

4. Related Statutes or rules:

Section 601.41 (8), Stats., authorized the commissioner to develop a uniform application for health insurance to be used in the small employer market. Section Ins 8.49, Wis. Adm. Code implemented the requirement for development of the uniform application for small employers. The commissioner used portions of the small employer application that is applicable to the individual health insurance application.

5. The plain language analysis and summary of the proposed rule:

The proposed rule was developed with the assistance of an advisory council charged with developing the uniform application questions and format to be used exclusively in the individual major medical health insurance market. The advisory council met six times between October 2009 and June 2010. The council members included intermediaries, public members, consumer advocates and representatives from the insurance industry.

As charged, the council recommended the proposed uniform application questions and format after reviewing applications used in the state for individual major medical health insurance and the model utilized by the State of Oregon.

The proposed rule requires insurers to develop policies and procedures to implement the new individual uniform application, restricts modifications, prescribes how the individual uniform application can be used when completed using internet access to the insurer or when the application is completed via telephone. The proposed rule prohibits insurers from automatically completing portion in the electronic version based on responses to various questions but does allow the insurer to rearrange the sequence as pull-down questions provided the printed form is in the required format as contained in Appendix 1.

Appendix 1 is the individual uniform application that once applicable, contains the only questions and format that can be used by insurers offering individual major medical health insurance.

Insurers will be permitted to add as separate forms that describe additional terms of the policy such as coinsurance, copayment and deductibles, payment mode, network selection. Additionally insurers will be permitted to add as a separate form the authorizations necessary to be compliant with Health Insurance Portability Accountability Act of 1996 (HIPAA) P.L. 104-191.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

There is no existing or proposed federal regulation related to uniform questions and format of an application for individual health insurance. Recently, the federal government passed P.L. 111-148 and P.L. 111-152, federal health care reform, that will place restrictions on individual health insurance products but the laws do not prescribe uniform questions and format for individual health insurance.

7. Comparison of similar rules in adjacent states as found by OCI:

Iowa: None as to the uniform questions and format for individual health insurance.

Illinois: Recently enacted Public Act 95-857, requiring the development and use of uniform health applications for small group and individual health insurance. The applications are to be used beginning January 1, 2011. The applications are still being developed by the state.

Minnesota: None as to the uniform questions and format for individual health insurance.

Michigan: None as to the uniform questions and format for individual health insurance.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

The commissioner in working with the advisory council sought the greatest common factor among insurers as to their current application and underwriting process to minimize changes that insurers will need to make to their underwriting process.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

There are no insurers that offer health insurance that qualify as small businesses in accordance with s. 227.114 (1), Wis. Stat. Intermediaries that solicit individual health insurance will be required to use the new form but since it is available at no cost from the office, the effect will be minimal.

10. If these changes may have a significant fiscal effect on the private sector, the anticipated costs to be incurred by private sector in complying with the rule:

There will be no significant fiscal effect on the private sector as the proposed rules will assist individuals by utilizing one form when applying for individual major medical health insurance.

11. Effect on Small Business:

This rule will necessitate the use of the uniform questions and format for application for individual health insurance; however the effect is not significant.

The proposed rule changes are:

SECTION 1. Section Ins 3.33 is created to read:

Ins 3.33 **Individual uniform application for health insurance. (1)** DEFINITIONS**.** For purposes of this section:

(a) "Individual major medical health insurance policy" means a comprehensive health care plan offered by an insurer authorized to write individual health or disability insurance for an individual or family. Individual major medical health insurance policies excludes limited-scope dental and vision policies, specified disease policies, short-term medical, hospital indemnity and other limited-benefit individual insurance products and policies issued by an association plan under a group policy that may be underwritten on an individual basis.

(b) "Individual uniform application" means the uniform questions and format for applications that are to be used by insurers offering individual major medical health insurance policies or certificates, including an individual major medical health insurance coverage provided through an association as individual coverage and underwritten on an individual basis and issued to individuals or families, as it appears as form OCI 26-503 in Appendix 1.

(2) APPLICATION FORMAT AND REQUIREMENTS. (a) In accordance with s. 601.41 (10), Stats., insurers offering individual major medical health insurance policies or certificates must use the questions in the same format as in form OCI 26-503 contained in Appendix 1 as the individual uniform application. The contents of the individual uniform application must not vary, except as permitted in sub. (3) (b), from the text or format including bold character, line spacing, the use of boxes around text and must use a type size of at least 10 points.

Note: A copy of the individual uniform application form OCI 26-503 (c. 06/2010), required in par. (a), may be obtained at no cost from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, WI 53707-7873, or at the Office's web address: oci.wi.gov.

(b) Insurers offering individual major medical health insurance policies or certificates

must implement procedures and policies necessary to implement and utilize the individual uniform application.

(c) Insurers offering individual major medical health insurance policies or certificates must treat and accept a paper copy of the individual major medical health insurance application as an original provided the application is received by the insurer within 45 days from the date the application form was originally signed.

(3) WEB-BASED APPLICATIONS. (a) Insurers offering individual major medical health insurance policies or certificates that permit applicants to complete the application through the insurer's website may not automatically populate or fill in answers to health questions on the application. An applicant shall answer each question. Insurers may change the order of questions but may not alter the content of any question from the individual uniform application. Insurers must separately request that the applicant respond to questions or information identified in par. (5). Insurers must send a paper copy of the completed application to the applicant. The paper copy of the completed application must be in the same format as appears in form OCI 26-503 as contained in Appendix 1 and comply with par. (6).

(b) If the insurer requires additional or clarifying information related to a response provided on the individual uniform application, an insurer may ask those questions as part of gathering the information contained in par. (5) or during a separate contact. Insurers must not gather information unrelated to responses requested on the individual uniform application. If an applicant discloses information that is not requested on the individual uniform application, an insurer must not use that information for purposes of underwriting or making a rescission or reformation decision.

(4) TELEPHONIC APPLICATIONS. (a) Insurers offering individual major medical health insurance policies or certificates may permit applicants to complete the application verbally with an authorized, licensed intermediary or with an employee of the insurer asking the applicant the questions. The intermediary or employee must ask the applicant each question on the uniform

individual applicant including each health question. Insurers may change the order of questions but may not alter the content of any question from the individual uniform application. Insurers must separately request that the applicant respond to questions or information identified in par. (5). Insurers must send a paper copy of the completed application to the applicant. The paper copy of the completed application must be in the same format as appears in form OCI 26-503 as contained in Appendix 1 and comply with par. (6).

(b) If the insurer requires additional or clarifying information related to a response provided on the individual uniform application, an insurer may ask those questions as part of gathering the information contained in par. (5) or during a separate contact. Insurers must not gather information unrelated to responses requested on the individual uniform application. If an applicant discloses information that is not requested on the individual uniform application, an insurer must not use that information for purposes of underwriting or making a rescission or reformation decision.

(5) ADDITIONAL REQUIREMENTS. (a) Insurers offering individual major medical health insurance policies or certificates must include a statement on the first page of the policy that the policy is guaranteed renewable except for the reasons stated s. 632.7495 (2), Stats.

(b) Insurers must include authorizations, releases and notices compliant with state and federal law filed with the office as separate forms that will be presented with the individual uniform application but not considered a part of the application.

(c) Insurers may file a separate form information or election options for the applicant to select deductible, copayment and coinsurance levels and elect, if applicable, provider networks. Additionally, insurers may include in the form premium payment options for the applicant to select.

(6) UNDERWRITING. Insurers shall comply with the provisions of s. Ins 3.28, including the requirement to return an accepted application as described in s. Ins 3.28 (5) (d), when underwriting a submitted individual uniform application.

SECTION 2. Section Ins 3.33, Appendix 1, is created to read:

s. Ins 3.33,
Appendix 1

INDIVIDUAL UNIFORM APPLICATION FOR INDIVIDUAL MAJOR MEDICAL HEALTH INSURANCE FORM

Ref: Section Ins 3.33, Wis. Adm. Code, and s. 601.41 (10), Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov

This form is designed for an individual's initial application for coverage. Please contact the insurer with questions regarding this form.

Instructions: Please complete the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application, please attach, sign and date each page.

I. INFORMATION

Primary Applicant/Insured Information:

First, Middle and Last Name				
Social Security No.*	Place of Birth	Birth Date	Gender	Height _____ Weight _____
Residential Address				
City	County	State	Zip Code	
Mailing Address, if different from residential address				
City	County	State	Zip Code	
Home Phone	Alternative Phone		Email (Optional)	

*If you have a Social Security Number.

The Primary Applicant is:

[ ] Single [ ] Married [ ] Under the age of 18**

**If primary applicant is under the age of 18, please complete sections – II. C. and V.

Employment Information:
Primary job duties:

Self-Employed: [ ] Yes [ ] No

II. ADDITIONAL APPLICANTS

A. Please complete ONLY if your spouse and/or children under the age of 27 are applying for coverage. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

Spouse Name (First; M.I.; Last)	Gender	Social Security Number*/ Place of Birth	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

Child Name (First; M.I.; Last)	Gender	Social Security Number*	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

B. Does the child(ren) named within this application live with you at the address shown above?

[ ] Yes [ ] No If "No," please list the child(ren)'s name and mailing address(es):

Mailing Address Named Applicant			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child.			

C. If the primary applicant is under the age of 18, provide the name and mailing address of the legal guardian or custodial parent:

Mailing Address Legal Guardian or Custodial Parent			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child			

III. CURRENT AND PREVIOUS COVERAGE

Please provide information about you or your dependent's individual or group health insurance coverage or other health coverage (either prior or current). It will help us determine whether you will have any waiting periods for preexisting conditions for the health insurance you are applying for. By providing this information you are not reducing your health insurance.

Does anyone applying for coverage have current health coverage?

[ ] Yes [ ] No If "Yes," please indicate insurer and applicant _____.

Has any applicant had health insurance coverage within the last 18 months?
[ ] Yes [ ] No If "Yes," please indicate insurer and applicant_____.

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted?
[ ] Yes [ ] No

Is any applicant enrolled in Medicare?
[ ] Yes [ ] No If "Yes," name of applicant _____. For this applicant, please stop here – this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid or other governmental health programs (i.e. BadgerCare, TRICARE, Veterans services)?
[ ] Yes [ ] No If "Yes," name of applicant _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

IV. MEDICAL INFORMATION

NOTICE TO APPLICANT:

The insurance company does not use or collect genetic information for any Underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the insurance company in any manner. For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.

You are required to disclose information regarding any disease or condition for which:

- Any applicant has been diagnosed or treated by any healthcare provider.
- Any applicant has had testing with abnormal results.
- Any applicant is awaiting test results.
- Any applicant has been recommended or scheduled for diagnostic testing, consultation, treatment, follow-up, or surgery.
- Any applicant has taken or has been advised to take any prescription medication.
- Any change in health status for which any applicant has not sought medical care or treatment.

Within the last FIVE (5) YEARS has anyone, including you or any family member requesting coverage, received counseling, care or treatment, medication, medical advice or been told a diagnosis for any of the conditions or illnesses listed below? (Please check all conditions that apply.)

Please mark "Yes" or "No" for each item, for you and any family members requesting coverage. Provide additional information for each question you answer "Yes" to on the Additional Medical Details page that follows the health questions.

Answers to the medical questions should be complete, true and correct to the best of your knowledge. You are required to promptly notify us if there is a change in your or your family's health prior to the effective date of coverage and provide updated information. If at any time during the underwriting process prior to the effective date of coverage, you or your health history changes, please notify us immediately as this may impact your coverage.

WITHIN THE LAST FIVE (5) YEARS:

1. Infectious and Parasitic Diseases

a. AIDS (acquired immunodeficiency syndrome), ARC (AIDS-related complex), HIV positive [The reporting of HIV test results is limited to FDA-licensed tests, and [ ] Yes [ ] No

you need not report results of tests conducted at an anonymous counseling and testing site or through the use of a home test kit.]	
b. Lyme's Disease	[ ] Yes [ ] No
c. Sexually transmitted disease(s).....	[ ] Yes [ ] No

2. Blood, Gland, Endocrine, Metabolic and Immune Disorders (other than HIV, ARC, AIDS)

a. Anemia/blood disorder	[ ] Yes [ ] No
b. Thyroid disease	[ ] Yes [ ] No
c. Diabetes/high or low blood sugar. ..... (If "Yes," record last HGA1C reading and date on the Additional Medical Details page.)	[ ] Yes [ ] No
d. Adrenal disorder	[ ] Yes [ ] No
e. Enlargement of lymph nodes	[ ] Yes [ ] No
f. Endocrine/gland/hormone system.....	[ ] Yes [ ] No

3. Cancer, Cyst and Tumors

c. Cancer. ..... (If "Yes," include the stage, type and location of the tumor on the Additional Medical Details page.)	[ ] Yes [ ] No
b. Tumors, cyst, lump, polyp.....	[ ] Yes [ ] No

4. Mental/Nervous/Behavioral Disorders

a. Alcohol/chemical/drug abuse/dependency	[ ] Yes [ ] No
b. Has any applicant used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs?.....	[ ] Yes [ ] No
c. Eating disorders such as, but not limited to, anorexia or bulimia.....	[ ] Yes [ ] No
d. Mental/emotional condition/depression.....	[ ] Yes [ ] No
e. Autism	[ ] Yes [ ] No
f. Suicide attempt	[ ] Yes [ ] No
g. Alcohol, chemical, drug abuse therapy, treatment or counseling within last 5 years..... (if "Yes," record date of last session in on the Additional Medical Details page)	[ ] Yes [ ] No

5. Brain and Nervous System

a. Brain disease or injury/concussion	[ ] Yes [ ] No
b. Convulsion/seizures/epilepsy.....	[ ] Yes [ ] No
c. Chronic headaches/migraines.....	[ ] Yes [ ] No
d. Neurological condition/disease/injury	[ ] Yes [ ] No
e. Sleep apnea/chronic sleep disorder	[ ] Yes [ ] No
f. Stroke	[ ] Yes [ ] No
g. Multiple Sclerosis	[ ] Yes [ ] No
h. Paralysis.....	[ ] Yes [ ] No

6. Skin Disorders

a. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer	[ ] Yes [ ] No

7. Eyes, Ears, Nose

a. Chronic ear/nose condition/disease	[ ] Yes [ ] No
b. Chronic eye condition/disease	[ ] Yes [ ] No
c. Cataracts/glaucoma	[ ] Yes [ ] No

8. Mouth, Throat or Jaw

a. Chronic throat/tonsil/adenoid/disease/disorder	[ ] Yes [ ] No
b. TMJ/jaw joint	[ ] Yes [ ] No

9. Heart or Circulatory System

a. Blood/circulatory disorder	[ ] Yes [ ] No
b. Heart attack/chest pain/murmur/angina	[ ] Yes [ ] No
c. Elevated/High cholesterol (if "Yes," record last reading and the date on the Additional Medical Details page)	[ ] Yes [ ] No
d. Elevated/High or low blood pressure (if "Yes," record last 3 readings and dates in past 12 months on the Additional Medical Details page)	[ ] Yes [ ] No
e. Phlebitis/blood clot	[ ] Yes [ ] No
f. Heart disease/disorder	[ ] Yes [ ] No

10. Respiratory System

a. Asthma	[ ] Yes [ ] No
b. Emphysema/Chronic obstructive pulmonary disease (COPD)	[ ] Yes [ ] No
c. Chronic respiratory/lung condition	[ ] Yes [ ] No
d. Pneumonia/bronchitis	[ ] Yes [ ] No

11. Digestive System

a. Appendicitis/chronic abdominal pain	[ ] Yes [ ] No
b. Blood in stool	[ ] Yes [ ] No
c. Colon/rectum/intestine/bowel/Crohn's disease	[ ] Yes [ ] No
d. Ulcer/esophageal reflux	[ ] Yes [ ] No
e. Gallbladder	[ ] Yes [ ] No
f. Liver condition/hepatitis/pancreas	[ ] Yes [ ] No

12. Urinary System

a. Bladder/urinary tract	[ ] Yes [ ] No
b. Kidney/kidney stones	[ ] Yes [ ] No

13. Male or Female Reproductive Systems

a. Breast (lumps or masses)	[ ] Yes [ ] No
b. Prostate/elevated PSA/prostatitis	[ ] Yes [ ] No
c. Reproductive system disorder/infertility/dysfunction	[ ] Yes [ ] No
d. Abnormal pap smear or mammography	[ ] Yes [ ] No

14. Pregnancy, Birth or Congenital Abnormalities

a. Birth defect/congenital deformities	[ ] Yes [ ] No

b. Pregnancy complications	[ ] Yes [ ] No
c. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date _____.)	[ ] Yes [ ] No

15. Muscular or Skeletal System

a. Back/neck/spine disorder	[ ] Yes [ ] No
b. Bone/orthopedic disorder	[ ] Yes [ ] No
c. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia	[ ] Yes [ ] No
d. Osteoarthritis/osteoporosis/osteopenia	[ ] Yes [ ] No
e. Rheumatoid arthritis	[ ] Yes [ ] No
f. Knee/shoulder/hip/joint surgery/disorder	[ ] Yes [ ] No
g. Hernia	[ ] Yes [ ] No

16. Miscellaneous

a. Cosmetic surgery/implants	[ ] Yes [ ] No
b. Use of prosthetic devices/limbs	[ ] Yes [ ] No
c. Had chronic fatigue	[ ] Yes [ ] No
d. Is any person to be insured now disabled, on disability, or unable to perform normal work or age-related activities	[ ] Yes [ ] No
e. Any fluctuations in weight (+/- 20lbs) in the past 12 months	[ ] Yes [ ] No
f. Implantable devices/stents/shunts/pace maker	[ ] Yes [ ] No
g. Allergies	[ ] Yes [ ] No
h. Transplants	[ ] Yes [ ] No

17. Other Injury, Illness, Treatment or Condition

a. Within the last 5 years, has any applicant had any other injury, illness, treatment, or condition not already listed; been hospitalized or scheduled to be hospitalized; had surgery or had surgery scheduled; had a test or a test scheduled; been recommended to have a test or surgery that was not performed for any reason not already mentioned; been prescribed medication for a condition or injury not already mentioned? (We are NOT seeking the results of HIV Antibody test.)	[ ] Yes [ ] No

18. Tobacco Use

a. Has any applicant used tobacco products in any form within the last 12 months?	[ ] Yes [ ] No
If "Yes", provide the name of applicant(s), amount of tobacco used and frequency:	

19. Other Activities

a. Has any applicant been involved in or participated in organized motorized racing or other extreme activities?	[ ] Yes [ ] No
If "Yes", provide the name of applicant(s), activity and frequency of the activity:	

ONLY complete this section if you need assistance with completing the medical information portion of this Application. Please note that this may require additional time to process your application.

Please contact me at this phone number during business hours:

I am unavailable during business hours, please contact me at this number during evenings or weekends:

Additional Medical Details Page
For any "Yes" responses in the medical information questions, please provide complete details below. Not providing complete details will delay the application process. Within the last five years has anyone been prescribed medications that were recommended or received from a licensed health care professional? Use an additional sheet(s) of paper if necessary. **<u>All additional pages must be signed and dated by the primary applicant.</u>**

Question # or additional information								
Applicant Name								
Specific Diagnosis & Type of Treatment								
Duration of Condition	**Began mm/yy**		**Began mm/yy**		**Began mm/yy**		**Began mm/yy**	
	End mm/yy		**End mm/yy**		**End mm/yy**		**End mm/yy**	
Name/ Dosage/ Frequency of medication & Dates of Medication Use	**Name of Rx**		**Name of Rx**		**Name of Rx**		**Name of Rx**	
	Dose		**Dose**		**Dose**		**Dose**	
	Began mm/yy	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**
Was surgery performed								
Description of surgery/ Procedures/ Tests/Result & Dates								
Current Status/ O-Ongoing/ R-Resolved								
Readings for Blood Pressure, Cholesterol & Diabetes	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**
Physician/ Hospital Name, City, State								

V. TERMS AND CONDITIONS

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified the person(s) who assisted me. I agree that the answers are, to the best of my knowledge and ability, complete and true.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company on the certificate or policy.

I understand that any intentional misrepresentation relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a family member made an intentional misrepresentation in the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application that is intended to mislead an insurer or conceal significant information about the applicant.

I understand that I may request a copy of this Application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original.

Signature (or e-signature) of Primary Applicant (If Primary Applicant is under the age of 18, Signature of legal guardian or custodial parent)	**Date Signed**
Signature (or e-signature) of Spouse	**Date Signed**

Signature (or e-signature) of each listed child who has attained the age of 18

Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**Date Signed**

Complete this section if someone assisted you in the completion of this Application

The following person assisted me in completing the Application:
Please explain the assistant's relationship to you and your family:

SECTION 3. These changes will take effect on the first day of the first month after publication, as provided in s. 227.22(2) (intro.), Stats.

SECTION 4. These changes first apply to policies issued on or after July 1, 2011.

SECTION 5. This section may be enforced under s. 601.41, 601.64, 601.65, or 628.10, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

Dated at Madison, Wisconsin, this _____ day of August, 2010.

Kimberly A. Shaul
Deputy Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

for section Ins 3.33 relating to uniform questions and format for individual health insurance

This rule change will have no significant effect on the private sector regulated by OCI.

Division of Executive Budget and Finance
DOA-2047 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE WORKSHEET

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL ☐ UPDATED		LRB Number	Amendment No. if Applicable
☐ CORRECTED ☐ SUPPLEMENTAL		Bill Number	Administrative Rule Number **INS 333**

Subject
uniform questions and format for individual health insurance

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	**Annualized Fiscal impact on State funds from:**	
A. State Costs by Category	**Increased Costs**	**Decreased Costs**
State Operations - Salaries and Fringes	**$ 0**	**$ -0**
(FTE Position Changes)	(**0** FTE)	(**-0** FTE)
State Operations - Other Costs	**0**	**-0**
Local Assistance	**0**	**-0**
Aids to Individuals or Organizations	**0**	**-0**
TOTAL State Costs by Category	**$ 0**	**$ -0**
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	**$ 0**	**$ -0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	**$ 0**	**$ -0**
GPR Earned	**0**	**-0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
TOTAL State Revenues	**$ 0 None**	**$ -0 None**

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ **None 0**	$ **None 0**
NET CHANGE IN REVENUES	$ **None 0**	$ **None 0**

Prepared by:	**Telephone No.**	**Agency**
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)

Division of Executive Budget and Finance
DOA-2048 (R10/2000)

Wisconsin Department of Administration

FISCAL ESTIMATE

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 333**

Subject
uniform questions and format for individual health insurance

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others _____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected ☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

Long-Range Fiscal Implications

None

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date (mm/dd/ccyy)**