Senate Bill No. 319–Senator Shaffer

CHAPTER.....

AN ACT relating to insurance; restricting the use by an insurer of information included in the consumer credit report of an applicant or policyholder as a basis for making certain determinations and taking certain actions regarding policies of insurance, and providing for related procedures, duties, restrictions and exceptions; revising the membership of certain boards; providing that any refund of an assessment by the Division of Industrial Relations of the Department of Business and Industry must include payment for interest earned; providing that hearing officers and appeals officers shall designate the location of certain hearings; requiring the Commissioner of Insurance to conduct a study relating to the Investments of Insurers Model Act adopted by the National Association of Insurance Commissioners; requiring the Commissioner to prepare and submit to the Governor and the Legislature a report concerning certain matters relating to the use of credit information in making decisions related to insurance; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. (Deleted by amendment.)

Sec. 1.5. Chapter 686A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 15, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 15, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 8, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Adverse action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with any policy.***

Sec. 4. ***"Affiliate" means any company that controls, is controlled by, or is under common control with another company.***

Sec. 5. ***"Consumer credit report" means any written, oral or other communication of information by a consumer reporting agency bearing on the credit worthiness, credit standing or credit capacity of an applicant or policyholder, and which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine:***

1. Whether to issue, cancel or renew a policy; or

2. The amount of the premium for a policy.

Sec. 6. *"Consumer reporting agency" means any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer credit reports to third parties.*

Sec. 7. *"Credit information" means any information that is related to credit and derived from a consumer credit report, found on a consumer credit report or provided on an application for a policy. The term does not include information that is not related to credit, regardless of whether it is contained in a consumer credit report or in an application for a policy, or is used to calculate an insurance score.*

Sec. 8. *"Insurance score" means a number or rating that is derived from an algorithm, computer application, model or other process that is based in whole or in part on credit information for the purposes of predicting the future losses or exposure with regard to an applicant or policyholder.*

Sec. 9. *The provisions of sections 2 to 15, inclusive, of this act do not apply to a contract of surety insurance issued pursuant to chapter 691B of NRS or any commercial or business policy.*

Sec. 10. *An insurer that uses information from a consumer credit report shall not:*

1. Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status or nationality of the consumer as a factor, or would otherwise lead to unfair or invidious discrimination.

2. Deny, cancel or fail to renew a policy on the basis of credit information unless the insurer also considers other applicable underwriting factors that are independent of credit information and not expressly prohibited by this section.

3. Base renewal rates for a policy upon credit information unless the insurer also considers other applicable factors independent of credit information.

4. Take an adverse action against an applicant or policyholder based on the applicant or policyholder not having a credit card account unless the insurer also considers other applicable factors independent of credit information.

5. Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating a policy unless the insurer does any one of the following:

(a) Treats the applicant or policyholder as otherwise approved by the Commissioner, after the insurer presents to the Commissioner information indicating that such an absence or inability relates to the risk for the insurer.

(b) Treats the applicant or policyholder as if the applicant or policyholder had neutral credit information, as defined by the insurer.

(c) Excludes the use of credit information as a factor, and uses only underwriting criteria other than credit information.

6. Take an adverse action against an applicant or policyholder based on credit information, unless an insurer obtains and uses a consumer credit report issued or an insurance score calculated within 90 days from the date the policy is first written or renewal is issued.

7. Except as otherwise provided in this subsection, use credit information regarding a policyholder without obtaining an updated consumer credit report regarding the policyholder and recalculating the insurance score at least once every 36 months. At the time of the annual renewal of a policyholder's policy, the insurer shall, upon the request of the policyholder or the policyholder's agent, reunderwrite and rerate the policy based upon a current consumer credit report or insurance score. An insurer need not, at the request of a policyholder or the policyholder's agent, recalculate the insurance score of or obtain an updated consumer credit report of the policyholder more frequently than once in any 12-month period. An insurer may, at its discretion, obtain an updated consumer credit report regarding a policyholder more frequently than once every 36 months, if to do so is consistent with the underwriting guidelines of the insurer. An insurer does not need to obtain an updated consumer credit report for a policyholder if any one of the following applies:

(a) The insurer is treating the policyholder as otherwise approved by the Commissioner.

(b) The policyholder is in the most favorably-priced tier of the insurer and all affiliates of the insurer. With respect to such a policyholder, the insurer may elect to obtain an updated consumer credit report if to do so is consistent with the underwriting guidelines of the insurer.

(c) Credit information was not used for underwriting or rating the policyholder when the policy was initially written. The fact that credit information was not used initially does not preclude an insurer from using such information subsequently when underwriting or rating such a policyholder upon renewal, if to do so is consistent with the underwriting guidelines of the insurer.

(d) The insurer reevaluates the policyholder at least once every 36 months based upon underwriting or rating factors other than credit information.

8. Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy:

(a) Credit inquiries not initiated by the applicant or policyholder, or inquiries requested by the applicant or policyholder for his or her own credit information.

(b) Inquiries relating to insurance coverage, if so identified on the consumer credit report.

(c) Collection accounts relating to medical treatment, if so identified on the consumer credit report.

(d) Multiple lender inquiries, if identified on the consumer credit report as being related to home loans or mortgages and made within 30 days of one another, unless only one inquiry is considered.

(e) Multiple lender inquiries, if identified on the consumer credit report as being related to a loan for an automobile and made within 30 days of one another, unless only one inquiry is considered.

Sec. 11. *If it is determined pursuant to the dispute resolution process set forth in section 611(a) of the federal Fair Credit Reporting Act, 15 U.S.C. § 1681i(a), that the credit information of a policyholder was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the policyholder, the insurer shall reunderwrite and rerate the policyholder within 30 days of receiving the notice. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the policyholder has overpaid a premium, the insurer shall refund to the policyholder the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual period of the policy.*

Sec. 12. *1. If an insurer uses credit information in underwriting or rating an applicant, the insurer or its agent shall disclose, either on the application for the policy or at the time the application is taken, that the insurer may obtain credit information in connection with the application. The disclosure must be written or provided to an applicant in the same medium as the application. The insurer need not provide the disclosure required pursuant to this section to a policyholder upon renewal of a policy if the policyholder was previously provided the disclosure in connection with the policy.*

2. An insurer may comply with the requirements of this section by providing the following statement:

> *In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that*

credit report. We may use a third party in connection with the development of your insurance score.

Sec. 13. *If an insurer takes an adverse action based upon credit information, the insurer shall:*

1. Provide notice to the applicant or policyholder that an adverse action has been taken, in accordance with the requirements of section 615(a) of the federal Fair Credit Reporting Act, 15 U.S.C. § 1681m(a).

2. Provide notice to the applicant or policyholder explaining the reasons for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take the adverse action. The notice must include a description of not more than four factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history," "poor credit rating" or "poor insurance score" does not meet the requirements of this subsection. Standardized explanations provided by consumer reporting agencies are deemed to comply with this section.

Sec. 14. *1. An insurer shall indemnify, defend and hold harmless an agent of the insurer from and against all liability, fees and costs arising out of or relating to the actions, errors or omissions of the agent with regard to obtaining or using credit information or insurance scores for the insurer, if the agent follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation.*

2. This section does not provide, expand, limit or prohibit any cause of action an applicant or policyholder may have against an agent of an insurer.

Sec. 15. *1. A consumer reporting agency shall not provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with:*

(a) An inquiry by or for an insurer about the credit information of an applicant or policyholder; or

(b) A request for a credit report or insurance score.

2. The information described in subsection 1 includes, without limitation:

(a) The expiration date of a policy or any other information that may identify time periods during which a policy of an applicant or policyholder may expire; and

(b) The terms and conditions of the coverage provided by a policy of an applicant or policyholder.

3. The restriction set forth in subsection 1 does not apply to data or lists the consumer reporting agency supplies to the insurer, or an agent or affiliate of the insurer, from whom the information was received.

4. The provisions of this section do not restrict any insurer from being able to obtain a report regarding a motor vehicle or a report of a history of claims.

Sec. 16. NRS 686C.140 is hereby amended to read as follows:

686C.140 1. The Board of Directors of the Association consists of not less than five nor more than nine members, serving terms as established in the plan of operation.

2. The members of the Board who represent insurers must be selected by member insurers subject to the approval of the Commissioner. ***If practicable, one of the members of the Board must be an officer of a domestic insurer.***

3. Two public representatives must be appointed to the Board by the Commissioner. A public representative may not be an officer, director or employee of an insurer or engaged in the business of insurance.

4. Vacancies on the Board must be filled for the remaining period of the term by majority vote of the members of the Board, subject to the approval of the Commissioner, for members who represent insurers, and by the Commissioner for public representatives.

5. To select the initial Board of Directors, and initially organize the Association, the Commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer is entitled to one vote in person or by proxy. If the Board of Directors is not selected within 60 days after notice of the organizational meeting, the Commissioner may appoint the initial members to represent insurers in addition to the public representatives.

~~[2.]~~ ***6.*** In approving selections or in appointing members to the Board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

~~[3.]~~ ***7.*** Members of the Board may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board of Directors but members of the Board may not otherwise be compensated by the Association for their services.

Sec. 17. NRS 687A.050 is hereby amended to read as follows:

687A.050 1. The Board of Directors of the Association shall consist of not fewer than five nor more than nine persons. The members of the Board shall be appointed by the Commissioner and shall serve at his discretion. Vacancies on the Board shall be filled in the same manner as initial appointments.

2. A majority of the members appointed shall be the designated representatives of member insurers. ***If practicable, one of the members appointed as a designated representative of the member insurers must be an officer of a domestic insurer.*** The

Commissioner shall consider among other things whether all member insurers are fairly represented.

3. Members of the Board may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board of Directors.

Sec. 18. Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:

Unless otherwise provided by a specific statue, if a signature is required of any person, the person may provide as the signature of the person:

1. An original signature;

2. A facsimile signature; or

3. An electronic signature pursuant to the provisions of chapter 719 of NRS.

Sec. 19. NRS 687B.160 is hereby amended to read as follows:

687B.160 1. Every insurance policy must be executed in the name of and on behalf of the insurer by its officer, attorney in fact, employee or representative duly authorized by the insurer.

2. ~~[A facsimile signature of any]~~ ***Any*** such executing individual may ~~[be used]~~ ***use,*** in lieu of an original signature ~~[.]~~ ***:***

(a) A facsimile signature; or

(b) An electronic signature pursuant to the provisions of chapter 719 of NRS.

3. An insurance contract issued before, on or after January 1, 1972, which is otherwise valid is not rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the policy.

Sec. 20. NRS 232.680 is hereby amended to read as follows:

232.680 1. The cost of carrying out the provisions of NRS 232.550 to 232.700, inclusive, and of supporting the Division, a full-time employee of the Legislative Counsel Bureau and the Fraud Control Unit for Industrial Insurance established pursuant to NRS 228.420, and that portion of the cost of the Office for Consumer Health Assistance established pursuant to NRS 223.550 that is related to providing assistance to consumers and injured employees concerning workers' compensation, must be paid from assessments payable by each insurer, including each employer who provides accident benefits for injured employees pursuant to NRS 616C.265.

2. The Administrator shall assess each insurer, including each employer who provides accident benefits for injured employees pursuant to NRS 616C.265. To establish the amount of the assessment, the Administrator shall determine the amount of money necessary for each of the expenses set forth in subsections 1 and 4 of this section and subsection 3 of NRS 616A.425 and determine the amount that is payable by the private carriers, the self-insured

employers, the associations of self-insured public or private employers and the employers who provide accident benefits pursuant to NRS 616C.265 for each of the programs. For the expenses from which more than one group of insurers receives benefit, the Administrator shall allocate a portion of the amount necessary for that expense to be payable by each of the relevant group of insurers, based upon the expected annual expenditures for claims of each group of insurers. After allocating the amounts payable among each group of insurers for all the expenses from which each group receives benefit, the Administrator shall apply an assessment rate to the:

(a) Private carriers that reflects the relative hazard of the employments covered by the private carriers, results in an equitable distribution of costs among the private carriers and is based upon expected annual premiums to be received;

(b) Self-insured employers that results in an equitable distribution of costs among the self-insured employers and is based upon expected annual expenditures for claims;

(c) Associations of self-insured public or private employers that results in an equitable distribution of costs among the associations of self-insured public or private employers and is based upon expected annual expenditures for claims; and

(d) Employers who provide accident benefits pursuant to NRS 616C.265 that reflect the relative hazard of the employments covered by those employers, results in an equitable distribution of costs among the employers and is based upon expected annual expenditures for claims.

The Administrator shall adopt regulations that establish the formula for the assessment and for the administration of payment, and any penalties that the Administrator determines are necessary to carry out the provisions of this subsection. The formula may use actual expenditures for claims. As used in this subsection, the term "group of insurers" includes the group of employers who provide accident benefits for injured employees pursuant to NRS 616C.265.

3. Federal grants may partially defray the costs of the Division.

4. Assessments made against insurers by the Division after the adoption of regulations must be used to defray all costs and expenses of administering the program of workers' compensation, including the payment of:

(a) All salaries and other expenses in administering the Division, including the costs of the office and staff of the Administrator.

(b) All salaries and other expenses of administering NRS 616A.435 to 616A.460, inclusive, the offices of the Hearings Division of the Department of Administration and the programs of self-insurance and review of premium rates by the Commissioner of Insurance.

(c) The salary and other expenses of a full-time employee of the Legislative Counsel Bureau whose principal duties are limited to conducting research and reviewing and evaluating data related to industrial insurance.

(d) All salaries and other expenses of the Fraud Control Unit for Industrial Insurance established pursuant to NRS 228.420.

(e) Claims against uninsured employers arising from compliance with NRS 616C.220 and 617.401.

(f) That portion of the salaries and other expenses of the Office for Consumer Health Assistance established pursuant to NRS 223.550 that is related to providing assistance to consumers and injured employees concerning workers' compensation.

5. If the Division refunds any part of an assessment, the Division shall include in that refund any interest earned by the Division from the refunded part of the assessment.

Sec. 21. NRS 616A.425 is hereby amended to read as follows:

616A.425 1. There is hereby established in the State Treasury the Fund for Workers' Compensation and Safety as an enterprise fund. All money received from assessments levied on insurers and employers by the Administrator pursuant to NRS 232.680 must be deposited in this Fund.

2. All assessments, penalties, bonds, securities and all other properties received, collected or acquired by the Division for functions supported in whole or in part from the Fund must be delivered to the custody of the State Treasurer for deposit to the credit of the Fund.

3. All money and securities in the Fund must be used to defray all costs and expenses of administering the program of workmen's compensation, including the payment of:

(a) All salaries and other expenses in administering the Division of Industrial Relations, including the costs of the office and staff of the Administrator.

(b) All salaries and other expenses of administering NRS 616A.435 to 616A.460, inclusive, the offices of the Hearings Division of the Department of Administration and the programs of self-insurance and review of premium rates by the Commissioner.

(c) The salary and other expenses of a full-time employee of the Legislative Counsel Bureau whose principal duties are limited to conducting research and reviewing and evaluating data related to industrial insurance.

(d) All salaries and other expenses of the Fraud Control Unit for Industrial Insurance established pursuant to NRS 228.420.

(e) Claims against uninsured employers arising from compliance with NRS 616C.220 and 617.401.

(f) That portion of the salaries and other expenses of the Office for Consumer Health Assistance established pursuant to NRS

223.550 that is related to providing assistance to consumers and injured employees concerning workers' compensation.

4. The State Treasurer may disburse money from the Fund only upon written order of the Controller.

5. The State Treasurer shall invest money of the Fund in the same manner and in the same securities in which he is authorized to invest state general funds which are in his custody. Income realized from the investment of the assets of the Fund must be credited to the Fund.

6. The Commissioner shall assign an actuary to review the establishment of assessment rates. The rates must be filed with the Commissioner 30 days before their effective date. Any insurer or employer who wishes to appeal the rate so filed must do so pursuant to NRS 679B.310.

7. If the Division refunds any part of an assessment, the Division shall include in that refund any interest earned by the Division from the refunded part of the assessment.

Sec. 22. NRS 616C.330 is hereby amended to read as follows:

616C.330 1. The hearing officer shall:

(a) Within 5 days after receiving a request for a hearing, set the hearing for a date and time within 30 days after his receipt of the request ~~[.]~~ ***at a place in Carson City, Nevada, or Las Vegas, Nevada, or upon agreement of one or more of the parties to pay all additional costs directly related to an alternative location, at any other place of convenience to the parties, at the discretion of the hearing officer;***

(b) Give notice by mail or by personal service to all interested parties to the hearing at least 15 days before the date and time scheduled; and

(c) Conduct hearings expeditiously and informally.

2. The notice must include a statement that the injured employee may be represented by a private attorney or seek assistance and advice from the Nevada Attorney for Injured Workers.

3. If necessary to resolve a medical question concerning an injured employee's condition or to determine the necessity of treatment for which authorization for payment has been denied, the hearing officer may refer the employee to a physician or chiropractor of his choice who has demonstrated special competence to treat the particular medical condition of the employee. If the medical question concerns the rating of a permanent disability, the hearing officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians and chiropractors maintained by the Administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and injured employee otherwise agree

to a rating physician or chiropractor. The insurer shall pay the costs of any medical examination requested by the hearing officer.

4. If an injured employee has requested payment for the cost of obtaining a second determination of his percentage of disability pursuant to NRS 616C.100, the hearing officer shall decide whether the determination of the higher percentage of disability made pursuant to NRS 616C.100 is appropriate and, if so, may order the insurer to pay to the employee an amount equal to the maximum allowable fee established by the Administrator pursuant to NRS 616C.260 for the type of service performed, or the usual fee of that physician or chiropractor for such service, whichever is less.

5. The hearing officer shall order an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 to pay the charges of a provider of health care if the conditions of NRS 616C.138 are satisfied.

6. The hearing officer may allow or forbid the presence of a court reporter and the use of a tape recorder in a hearing.

7. The hearing officer shall render his decision within 15 days after:

(a) The hearing; or

(b) He receives a copy of the report from the medical examination he requested.

8. The hearing officer shall render his decision in the most efficient format developed by the Chief of the Hearings Division of the Department of Administration.

9. The hearing officer shall give notice of his decision to each party by mail. He shall include with the notice of his decision the necessary forms for appealing from the decision.

10. Except as otherwise provided in NRS 616C.380, the decision of the hearing officer is not stayed if an appeal from that decision is taken unless an application for a stay is submitted by a party. If such an application is submitted, the decision is automatically stayed until a determination is made on the application. A determination on the application must be made within 30 days after the filing of the application. If, after reviewing the application, a stay is not granted by the hearing officer or an appeals officer, the decision must be complied with within 10 days after the refusal to grant a stay.

Sec. 23. NRS 616C.345 is hereby amended to read as follows:

616C.345 1. Any party aggrieved by a decision of the hearing officer relating to a claim for compensation may appeal from the decision by filing a notice of appeal with an appeals officer within 30 days after the date of the decision.

2. If a dispute is required to be submitted to a procedure for resolving complaints pursuant to NRS 616C.305 and:

(a) A final determination was rendered pursuant to that procedure; or

(b) The dispute was not resolved pursuant to that procedure within 14 days after it was submitted,

any party to the dispute may file a notice of appeal within 70 days after the date on which the final determination was mailed to the employee, or his dependent, or the unanswered request for resolution was submitted. Failure to render a written determination within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request.

3. Except as otherwise provided in NRS 616C.380, the filing of a notice of appeal does not automatically stay the enforcement of the decision of a hearing officer or a determination rendered pursuant to NRS 616C.305. The appeals officer may order a stay, when appropriate, upon the application of a party. If such an application is submitted, the decision is automatically stayed until a determination is made concerning the application. A determination on the application must be made within 30 days after the filing of the application. If a stay is not granted by the officer after reviewing the application, the decision must be complied with within 10 days after the date of the refusal to grant a stay.

4. Except as otherwise provided in ~~[this subsection,]~~ ***subsection 5,*** the appeals officer shall, within 10 days after receiving a notice of appeal pursuant to this section or a contested claim pursuant to subsection 5 of NRS 616C.315 ~~[, schedule]~~ ***:***

(a) Schedule a hearing on the merits of the appeal or contested claim for a date and time within 90 days after his receipt of the notice ***at a place in Carson City, Nevada, or Las Vegas, Nevada, or upon agreement of one or more of the parties to pay all additional costs directly related to an alternative location, at any other place of convenience to the parties, at the discretion of the appeals officer;*** and ~~[give]~~

(b) Give notice by mail or by personal service to all parties to the matter and their attorneys or agents at least 30 days before the date and time scheduled.

5. A request to schedule the hearing for a date and time which is:

(a) Within 60 days after the receipt of the notice of appeal or contested claim; or

(b) More than 90 days after the receipt of the notice or claim,

may be submitted to the appeals officer only if all parties to the appeal or contested claim agree to the request.

~~[5.]~~ ***6.*** An appeal or contested claim may be continued upon written stipulation of all parties, or upon good cause shown.

~~[6.]~~ *7.* Failure to file a notice of appeal within the period specified in subsection 1 or 2 may be excused if the party aggrieved shows by a preponderance of the evidence that he did not receive the notice of the determination and the forms necessary to appeal the determination. The claimant, employer or insurer shall notify the hearing officer of a change of address.

Sec. 24. 1. The Commissioner of Insurance shall conduct a study to review whether the State of Nevada should enact, in the interest of the public:

(a) The Defined Limits Version of the Investments of Insurers Model Act adopted by the National Association of Insurance Commissioners;

(b) The Defined Standards Version of the Investments of Insurers Model Act adopted by the National Association of Insurance Commissioners; or

(c) Other legislation regulating the investments of insurers.

2. The Commissioner shall seek to obtain all relevant information from public and private sources as part of this study. Any such information obtained by the Commissioner may only be used for the purposes of conducting this study.

3. The Commissioner shall complete this study and submit a copy of his findings and recommendations on or before January 1, 2005, to the Director of the Legislative Counsel Bureau for distribution to the 73rd Session of the Nevada Legislature.

Sec. 25. 1. On or before December 31, 2004, the Commissioner of Insurance shall prepare a report and submit the report to the Governor and the Legislature. The report must address:

(a) The operation of sections 2 to 15, inclusive, of this act;

(b) The efficacy, necessity and desirability of using credit information in making decisions related to insurance;

(c) The impacts upon the residents of Nevada of the continued use of credit information in making decisions related to insurance; and

(d) Any additional consumer protections identified by the Commissioner for the consideration of the Legislature.

2. As used in this section, "credit information" has the meaning ascribed to it in section 7 of this act.

Sec. 26. 1. This section and sections 1 and 16 to 25, inclusive, of this act become effective on October 1, 2003.

2. Sections 1.5 to 15, inclusive, of this act become effective on July 1, 2004.