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Employment Law Summary

Georgia

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Health Insurance Mandates

State health insurance mandates are laws regulating the terms of coverage for **insured health plans**. Mandates can affect various parts of health insurance plans as follows:

- **Benefit mandates** require health insurance plans to cover specific treatments, services or procedures. In some cases, however, benefit mandates require issuers to *offer coverage* for specific treatments, services or procedures to employers for purchase.
- **Provider mandates** require health insurance plans to pay for services provided by specific health care professionals. Often, provider mandates are in the form of *nondiscrimination mandates* that require coverage only if the health plan already reimburses services within the scope of the health care professional's practice.
- **Person mandates** require health insurance plans to cover specific categories of people.

Additional mandates for health plans exist at the federal level. For example, the Affordable Care Act (ACA) requires non-grandfathered plans in the small group and individual markets to provide coverage for items and services designated as "essential health benefits." Health plan sponsors and issuers should work with their advisors to determine how to comply with applicable federal and state mandates.

This Employment Law Summary contains charts outlining Georgia's benefit, provider and person mandates for **insured group health plans** (referred to as "**plans**" throughout this document) issued in the state. Please keep in mind that the following charts do not address federal benefit mandates, such as those in the ACA. More information is available on the Georgia Office of Insurance and Safety Fire Commissioner website, or the Georgia Department of Law Consumer Protection Unit website.

Benefit Mandates

MANDATE	DESCRIPTION
Anesthesia for dental care	Plans must cover general anesthesia and associated hospital or ambulatory surgical facility charges in conjunction with dental care provided to an insured person: • Who is seven years of age or younger or is developmentally disabled; • For which a successful result may not be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition; or • Who has sustained extensive facial or dental trauma (unless otherwise covered by workers' compensation insurance). Plans may require prior authorization for this care in the same manner required for other covered medical care.
Autism	Plans sponsored by **employers with 11 or more employees** must cover the diagnosis and medically necessary treatment of autism spectrum disorders for insureds who are **20 years of age or younger**. A plan may limit coverage for applied behavior analysis to **$35,000 per year** but may not limit the number of visits.
Biomarker testing	Plans renewed or issued on or after **July 1, 2023**, must cover biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when the testing is supported by medical and scientific evidence.
Bone marrow transplants for breast cancer and Hodgkin's disease	Insurers must *offer coverage* for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease, to at least the same extent as a plan's coverage for other types of physical illnesses.
Cancer clinical trials – routine patient care for children	Plans that provide family coverage must cover routine patient care costs incurred in connection with clinical trial programs for covered **dependent children** who: • Were diagnosed with cancer prior to reaching age 19; • Are enrolled in an approved clinical trial program for treatment of children's cancer; and • Are not otherwise eligible for benefits, payments or reimbursements from any other source. These benefits may not be subject to greater cost-sharing or other requirements than those that apply for similar routine patient care that is not incurred in connection with a clinical trial.
Child wellness services	Plans must cover child wellness services for an insured child **from birth through age five**. This coverage may not be subject to a deductible. Child wellness services include periodic review of a child's physical and emotional status

MANDATE	DESCRIPTION
	conducted by a physician or pursuant to a physician's supervision but do not include periodic dental examinations or other dental services.
Child hearing aids	Plans must cover one hearing aid at a cost of **up to $3,000 per hearing impaired ear** for insureds who are **age 18 or younger**. This coverage must include replacement of one hearing aid per hearing impaired ear **every 48 months** and must be subject to the same annual deductible, coinsurance or copayment, or utilization review that applies to similar covered benefits.
Colorectal cancer screenings	Plans must cover colorectal cancer screenings, examinations and laboratory tests in accordance with guidelines from the American Cancer Society and deemed appropriate by the attending physician after conferring with the patient. These benefits must be subject to the same annual deductibles or coinsurance as those that apply to all other covered benefits.
Contraceptives	Plans that cover prescription drugs on an outpatient basis must cover any prescribed drug or device approved by the U.S. Food and Drug Administration (FDA) for use as a contraceptive. This coverage may not be subject to any copayment, coinsurance or fee that is not equally imposed upon individuals receiving benefits for prescription drugs who are in the same benefit category, class, coinsurance level or copayment level. This mandate does not require plans to cover abortions.
Dermatology – direct access	Plans may not require an insured to obtain a referral from a primary care physician as a condition for coverage of dermatological services.
Diabetes	Plans must cover medically necessary equipment, supplies, pharmacologic agents and outpatient self-management training and education, including medical nutrition therapy, for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes who adhere to the prognosis and treatment regimen prescribed by a licensed physician. This coverage must be subject to the same annual deductibles or coinsurance established for all other covered benefits.
Early prescription refills during emergencies	When the following conditions occur, plans must: • Waive time restrictions on prescription medication refills (which includes the suspension of electronic “refill too soon” limitations) to enable insureds to refill prescriptions in advance; • Authorize payment to pharmacies for a 30-day supply of any prescription medication, regardless of the date upon which the prescription had most recently been filled. These mandates apply when the person seeking the refill resides in a county or other area of Georgia that:

MANDATE	DESCRIPTION
	• Is declared to be under a state of emergency by the Governor's executive order; or • Is under a hurricane warning issued by the National Weather Service; **and** The prescription medication has refills remaining and a refill is requested within 30 days after the origination date of the above-referenced conditions (or until such conditions are terminated by the issuing authority or no longer exist).
Heart transplants	Insurers must *offer coverage* for human heart transplants to at least the same degree as a plan's coverage for other types of physical illnesses. This optional coverage: • Must include any charges for the acquisition, transportation or donation of a human heart when a transplant is performed; • May **not** be subject to any exclusion, reduction or other limitation as to coverage, deductibles or coinsurance requirements that do not apply generally to other similar benefits; and • May be subject to a waiting period or a delayed eligibility date for heart transplant benefits of no more than 12 months from the effective date of the coverage.
Mammograms	Plans must cover mammograms with at least the following frequency: • One base-line mammogram for any female who is **age 35-39 years old**; • One mammogram every two years for any female who is **age 40-49 years old**; • One mammogram every year for any female who is **at least 50 years old**; and • A mammogram when ordered by a physician for **a female at risk**. For this purpose, a female at risk is a woman: • Who has a personal history of breast cancer or of biopsy proven benign breast disease; • Whose grandmother, mother, sister or daughter has had breast cancer; or • Who has not given birth prior to age 30.
Mastectomies	Plans that cover mastectomies must also cover: • Inpatient care following a mastectomy or lymph node dissection for the appropriate period of stay as determined by the attending physician in consultation with the patient; and • Follow-up visits determined appropriate by the attending physician after consultation with the patient.
Maternity/Childbirth	Plans that cover maternity benefits must cover a minimum of the following for a mother and her newly born child: • **48 hours** of inpatient care following a normal vaginal delivery; and

MANDATE	DESCRIPTION
	• **96 hours** of inpatient care following a cesarean section. If a mother and newborn are discharged earlier, plans cover up to two follow-up visits, as long as the first visit occurs within 48 hours of discharge.
Mental disorders – small groups	Insurers must *offer* coverage for treatment of mental health or substance use disorders for children, adolescents and adults under **plans sponsored by employers with 50 or fewer employees**. This coverage: • Must be at least as extensive as a plan's coverage for treatment of physical illness (except as provided below) and subject to the same annual and lifetime dollar limits as that coverage; • May be subject to different limits on the number of inpatient treatment days and outpatient treatment visits; • May **not** be subject to any other exclusion, reduction or other limitation as to coverage that do not apply generally to other similar, covered benefits; • May be subject to separate deductibles or coinsurance provisions from those that apply generally to other similar, covered benefits (however, a separate deductible may not exceed the deductible for medical or surgical coverage); and • May **not** be subject to a separate out-of-pocket limit that exceeds the maximum out-of-pocket limit for medical or surgical coverage.
Mental disorders – large groups	Insurers must *offer* coverage for treatment of mental health or substance use disorders for children, adolescents and adults under **plans sponsored by employers with 51 or more employees**. This coverage: • Must be at least as extensive as a plan's coverage for treatment of physical illness and subject to the same annual and lifetime dollar limits as that coverage; • May **not** be subject to different limits on the number of inpatient treatment days and outpatient treatment visits; • May **not** be subject to any other exclusion, reduction or other limitation as to coverage that do not apply generally to other similar, covered benefits; and • May be subject to deductibles or coinsurance provisions. *The federal Mental Health Parity and Addiction Equity Act (MHPAEA) creates additional parity requirements for employers with more than 50 employees that offer mental health or substance use disorder benefits in their group health plans. Depending on a plan's design, the MHPAEA may require stricter parity requirements than state law mandates.*
Morbid obesity treatment	Insures may *offer coverage* for the treatment of morbid obesity, which means: • Either twice or 100 pounds over the ideal weight for an insured's frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;

MANDATE	DESCRIPTION
	• A body mass index (BMI) of 40 kilograms per meter squared; or • A BMI equal to or greater than 35 kilograms per meter squared when combined with medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes.
Obstetrical/gynecological services – direct access	Plans may not require an insured to obtain a referral from another physician as a condition for the coverage of services of an in-network obstetrician or gynecologist.
Off-label drug use	Plans that cover prescription drugs may not limit or exclude coverage of an FDA-approved drug on the basis that the drug has not been FDA-approved for the particular indication for which it was prescribed, as long as the drug has been recognized for the particular indication by certain standard reference compendium or medical journals and is prescribed for the treatment of: • A life-threatening disease or condition; • A chronic and seriously debilitating disease or condition, if the drug is medically necessary to treat that disease or condition and the drug is on the insurer's formulary or preferred drug list, if any; or • A disease or condition in a child where the drug has been FDA-approved for similar conditions or diseases in adults and the drug is medically necessary to treat that disease or condition. This coverage must be subject to the same annual deductibles or coinsurance established for all other covered benefits.
Off-label drug use – anti-cancer drug therapy	Plans that cover prescription drugs may **not** deny benefits for a covered drug on the grounds that the drug is not FDA-approved for the particular indication, as long as the drug is either: • Recognized for treatment of the indication in at least one standard reference compendium; or • Recommended for a particular type of cancer and found to be safe and effective in certain formal clinical studies.
Orally administered chemotherapy	Plans that cover intravenously administered or injected chemotherapy for the treatment of cancer must also cover orally administered chemotherapy for the treatment of cancer to the same extent, regardless of a plan's formulation or benefit category determination. Plans may comply with this mandate by limiting the total cost-sharing amount paid by an insured to no more than $200 per filled prescription for any orally administered chemotherapy.
Outpatient surgery	Under plans that cover medical and surgical procedures required to be performed on an inpatient basis, insurers must *offer coverage* for those same procedures performed on an outpatient basis under the following circumstances: • In the case of a medical emergency; or

MANDATE	DESCRIPTION
	• When the procedures are performed by a licensed medical practitioner operating with the use of local anesthetic at certain facilities, including the office of the licensed medical practitioner.
Ovarian cancer screenings	Plans must cover surveillance tests for women **age 35 and over** at risk for ovarian cancer, subject to the same annual deductibles or coinsurance established for all other covered benefits. For this purpose, a woman is considered at risk for ovarian cancer if she tests positive for certain gene mutations or has a family history of ovarian cancer.
Pap smears	Plans must cover at least one Pap smear per year for female insureds.
Parity in cost-sharing requirements for breast examinations	Plans that provide coverage for diagnostic examinations for breast cancer must include provisions to ensure that the cost-sharing requirements applicable to diagnostic and supplemental breast screening examinations are no less favorable than the cost-sharing requirements applicable to screening mammography for breast cancer. "Diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast, including using breast MRI, breast ultrasound, or mammogram, that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer, or an abnormality detected by another means of examination. If this would result in Health Savings Account ineligibility, such cost-sharing requirement generally applies only for HSA-qualified high deductible health plans with respect to the deductible of such plan after the minimum deductible has been satisfied.
Pregnancy complications	Plans that include maternity benefits must cover complications of pregnancy for all insureds who have been covered for under a plan for at least nine months or for a period of at least 30 days immediately prior to the date conception occurs or pregnancy commences. This coverage may **not** be subject to any exclusion, reduction or other limitation as to coverage, any deductible nor any coinsurance provision that does not apply generally to other covered benefits.
Prescription drugs – prorated cost-sharing	Plans that cover prescription drugs must permit and apply a prorated daily cost-sharing rate to prescriptions dispensed by a pharmacy for less than a 30 days' supply, if the prescriber or pharmacist indicates the fill or refill could be in the insured's best interest or is for the purpose of synchronizing the insured's medications.
Prescription inhalant refills	Plans that cover prescription drugs may not deny or limit coverage for refills of prescription inhalants that are required to enable insureds to breathe when suffering from asthma or other life-threatening bronchial ailments, if ordered or prescribed by a treating physician.

MANDATE	DESCRIPTION
Prostate specific antigen tests	Plans must cover annual prostate specific antigen tests for covered males who are: • **Age 45 or older**; and • **Age 40 or older**, if ordered by a physician.
Reasonable copayments	A plan's copayments must be reasonable in relation to the covered benefits to which they apply, must serve as an incentive rather than a barrier to access appropriate care, and cannot work so as to unfairly deny necessary healthcare services.
Stage four advanced, metastatic cancer	Plans that cover the treatment of stage four advanced, metastatic cancer may **not** limit or exclude coverage for an FDA-approved drug by conditioning its coverage on an insured's failure to successfully respond to a different drug, as long as the use of the drug is consistent with best practices for this treatment and is supported by peer reviewed medical literature.
Telehealth services	Plans must provide benefits for covered services that are appropriately provided through telehealth (in accordance with Georgia law and generally accepted health care practices and standards). Telehealth means the use of information and communications technologies, including, but not limited to, telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health related education, public health and health administration. Plans generally cannot require an in-person consultation or contact before receiving telemedicine services. Plans also cannot: • Impose any type of utilization review on telemedicine services unless it is imposed when the same services are provided in-person. • Restrict coverage of telemedicine services to services provided by a particular vendor, or third party, or services provided through a particular electronic communications technology platform; • Place restrictions on prescribing medications through telemedicine that are more restrictive than what is required through in-person consultation.
Temporomandibular joint dysfunction or functional deformities of the maxilla or mandible	Plans must cover medically necessary: • Surgical or nonsurgical treatment for the correction of temporomandibular joint (TMJ) dysfunction by physicians or dentists; and • Surgery for the correction of functional deformities of the maxilla and mandible. This coverage may be subject to the same coverage limitations, deductibles or coinsurance that apply to other benefits.
Terminal conditions	Plans may not restrict coverage for treatment of a terminal condition when it is prescribed by a physician as medically appropriate and agreed to by an insured,

MANDATE	DESCRIPTION
	as long as the care is consistent with best practices for treatment of the terminal condition and is supported by peer-reviewed medical literature.
Transplant coverage	Plans that provide coverage for anatomical gifts, organ transplants or related treatment and services cannot: • Deny coverage solely on the basis of a covered person's disability; • Deny eligibility, or continued eligibility, to enroll or to renew coverage solely for the purpose of avoiding this mandate; • Penalize or otherwise limit the reimbursement of an attending health care provider, or provide incentives to induce such provider to provide care to a covered person in a manner inconsistent with this mandate; or • Reduce or limit benefits for the medical or other health care services related to organ transplantation performed pursuant to this mandate (as determined in consultation with the attending health care provider and patient).

Provider Mandates

MANDATE	DESCRIPTION
Athletic trainers	Nondiscrimination mandates: Plans that cover any service within the lawful scope of these providers' licenses and practices must cover that service regardless of whether it is provided by a licensed doctor of medicine or by one of these providers acting within their lawful scopes.
Chiropractor	
Dentists	
Optometrists	
Psychologists	
Hospitals specializing in substance abuse treatment	Plans that provide specific benefits for treatment of alcoholism or drug addiction may not deny these benefits solely because they are provided by a licensed hospital that specializes in and is operated primarily for the treatment of alcoholics or drug addicts.
Pharmacy	Plans may not require an insured to obtain pharmaceutical services, including prescription drugs, exclusively from a mail-order pharmaceutical distributor. If a provider of pharmaceutical services has agreed to the same terms and conditions that apply to mail-order pharmaceutical distributors, an insured who does not utilize a mail-order distributor may not be required to pay a different copayment or be subject to any varying conditions that do not apply to services from a mail-order pharmaceutical distributor.
Registered nurse first assistant	Plans that cover the services of a surgical first assistant must reimburse any registered nurse first assistant who has rendered these services at the request of a physician and within the scope of his or her professional license. This mandate does not apply to a registered nurse first assistant who is employed by the

MANDATE	DESCRIPTION
	requesting physician or renders these services as an employee of the hospital where services are rendered.

Person Mandates

MANDATE	DESCRIPTION
Continuation coverage	Plans sponsored by employers with fewer than **20 employees** must offer continuation coverage when a covered employee's or dependent's coverage terminates (other than because of employment termination for cause or because of nonpayment of required contributions), if the individual has been covered for at least **six months**. The maximum length of state continuation coverage is generally **three months**. However, covered individuals who are **60 or older** may be eligible to continue coverage until they become eligible for Medicare.
Dependent coverage – full-time students	An insured's dependent child must continue to be eligible for coverage through **age 25** as long as: • Coverage of an insured parent or guardian continues in effect; • The child remains a dependent of the insured parent or guardian; and • The child, in each calendar year since reaching the policy's limiting age for dependents, has been enrolled for five calendar months or more as a full-time student at a postsecondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented due to illness or injury. *A federal law (Michelle's law) extends coverage for students with a serious illness or injury who take a medically necessary leave of absence. Under the federal provision, coverage is extended for one year from when the leave of absence begins unless, under the terms of the plan, coverage would terminate as of an earlier date.*
Disabled children	Plans that include a limiting age for coverage of dependent children must provide that attainment of the limiting age will not operate to terminate coverage for a child who is and continues to be: • Incapable of self-sustaining employment by reason of developmental disability or physical disability; and • Chiefly dependent upon the employee for support and maintenance.
Newly born or adopted children	Plans that provide family coverage must cover a newly born child of an insured from the moment of birth and an adopted child of the insured from the earlier of either the date of placement for adoption or the date of the final decree of adoption. This coverage must include benefits for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, but need not include benefits for routine well baby care.