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Statutes:

All laws specifically codified by the General Assembly of the State of Georgia through the 2025 Regular Session of the General Assembly.

Annotations of Judicial Decisions:

Case annotations reflecting decisions posted to LexisNexis® through May 12, 2025. These annotations will appear in the following traditional reporter sources: Georgia Reports; Georgia Appeals Reports; Southeastern Reporter; Supreme Court Reporter; Federal Reporter; Federal Supplement; Federal Rules Decisions; Lawyers' Edition; United States Reports; and Bankruptcy Reporter.

Annotations of Attorney General Opinions:

Constructions of the Official Code of Georgia Annotated, prior Codes of Georgia, Georgia Laws, the Constitution of Georgia, and the Constitution of the United States by the Attorney General of the State of Georgia posted to LexisNexis® through May 12, 2025.

Other Annotations:

References to:

Emory Bankruptcy Developments Journal.
Emory International Law Review.
Emory Law Journal.
Georgia Journal of International and Comparative Law.
Georgia Law Review.
Georgia State University Law Review.
John Marshall Law Review.
Mercer Law Review.
Georgia State Bar Journal.
Georgia Journal of Intellectual Property Law.
American Jurisprudence, Second Edition.
American Jurisprudence, Pleading and Practice Forms Annotated.
American Jurisprudence, Proof of Facts.
American Jurisprudence, Trials.
Corpus Juris Secundum.
Uniform Laws Annotated.
American Law Reports, First through Seventh Series.
American Law Reports, Federal.

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In Volume 41, a Table Eleven-A comparing provisions of the 1976 Constitution of Georgia to the 1983 Constitution of Georgia and a Table Eleven-B comparing provisions of the 1983 Constitution of Georgia to the 1976 Constitution of Georgia.

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CHAPTER 23

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Article 1

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ARTICLE 1

AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS

33-23-3. Agency licensing and biennial renewals; ownership restrictions.

(a) Each principal office of an agency shall obtain an agency license prior to commencement of operations and renew such license biennially prior to the last day of the origination month of such agency by filing application forms prescribed by the Commissioner.

(b) An agency shall be subject to all penalties, fines, criminal sanctions, and other actions authorized for agents under this title.

(c) No person shall be an owner of an agency or, if the agency is a corporation, no person shall be an officer or director of such corporation or own 10 percent or more of the corporation if such person has had his or her license under this title refused, revoked, or suspended.

History.
Code 1981, § 33-23-3, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 3; Ga. L. 2001, p. 925, § 1; Ga. L. 2011, p. 623, § 2/SB 251; Ga. L. 2012, p. 37, § 1/HB 477; Ga. L. 2019, p. 386, § 4/SB 133; Ga. L. 2025, p. 652, § 12/HB 410, effective May 14, 2025.
Amendments.
The 2025 amendment, effective May 14, 2025, rewrote subsection (a).

33-23-11. Issuance and contents of license; display certificate of licensure.

(a) The Commissioner shall issue licenses applied for to persons qualified for the licenses in accordance with this article.

(b) The license shall state the legal name and address of the licensee, the date of issue, the general conditions relative to expiration or termination, the kind or kinds of insurance covered if not an insurance agency license, and the other conditions of licensing.

(c) Upon the request of a licensee under this chapter, the Commissioner shall provide a certificate of licensure which shall be suitable for display at the business premises of the licensee. The Commissioner shall provide by rule or regulation the application procedures for the certificate and the form and content of the certificate.

(d) The Commissioner shall have the authority to enter into agreements with persons for the purposes of providing licensing testing, administrative, record keeping, printing, mounting, and other services related to the administration of the Commissioner's duties under this article and to set appropriate charges by rule or regulation to cover the costs of such services which shall be in addition to the fees otherwise provided for in this title and may be paid directly to the providers of such services. The Commissioner may require applicants for licenses to pay such charges for licensing testing and for the cost of the printing and mounting of a certificate of licensure which is suitable for display directly to the provider of such services. The Commissioner may require insurers to pay such charges for licensing testing, administrative, record keeping, and other services provided for in this subsection directly to the provider of such services in an amount corresponding to the number of their authorized agents.

History.
Code 1981, § 33-23-11, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1993, p. 702, § 1; Ga. L. 1995, p. 1348, § 2; Ga. L. 1997, p. 1296, § 7; Ga. L. 2001, p. 925, § 1; Ga. L. 2019, p. 386, § 6/SB 133; Ga. L. 2020, p. 138, § 3/SB 377; Ga. L. 2025, p. 652, § 13/HB 410, effective May 14, 2025.
Amendments.
The 2025 amendment, effective May 14, 2025, inserted "legal" near the beginning of subsection (b).

33-23-12. Limited licenses.

(a) Except as provided in subsection (b) of this Code section for credit insurance licenses, subsection (b.1) of this Code section, subsection (c)

of this Code section for rental companies, subsection (d) of this Code section for portable electronics, and subsection (f) of this Code section for travel insurance, the Commissioner may provide by rule or regulation for licenses which are limited in scope to specific lines or sublines of insurance.

(b)(1) Licenses shall be issued to individuals for the purpose of writing credit insurance as provided in this subsection.

(2) Resident applicants must be sponsored by an insurer authorized to write credit insurance in this state, and the applicant must certify that he or she has read and understands the provisions of this title and regulations promulgated pursuant to this title which are pertinent to credit insurance in this state.

(3) Nonresident applicants must follow the appointment process set forth in subsection (g) of Code Section 33-23-16.

(4) No prelicensing education or prelicensing examination shall be required for issuance of such license, and the insurer shall certify that the licensee has completed a minimum of five hours of self-study in credit insurance subjects.

(5) The lines or sublines of insurance included in the scope of authority of credit insurance licenses issued under this Code section shall include, but not be limited to, the following:

(A) Credit life and credit accident and sickness insurance;

(B) Credit casualty insurance;

(C) Credit property insurance;

(D) Credit unemployment insurance;

(E) Accidental death and dismemberment insurance;

(F) Nonfiling or nonrecording insurance;

(G) Vendors' single interest insurance; and

(H) Any other lines or sublines of insurance which may become accepted as credit insurance by the insurance and lending industries unless otherwise disapproved by the Commissioner.

(b.1)(1) In lieu of requiring individual employees to obtain a limited credit insurance license pursuant to the provisions of subsection (b) of this Code section, any business entity that sells, solicits, or negotiates the lines or sublines of credit insurance pursuant to paragraph (5) of subsection (b) of this Code section may make application to the Commissioner for a limited credit insurance agency license so long as:

(A) The entity examines the character and fitness of each of its employees that sell, solicit, or negotiate credit insurance on its behalf to the satisfaction of the Commissioner, including but not limited to performing criminal background checks;

(B) The entity provides at least five hours of training in minimum basic insurance concepts and credit insurance subjects to its employees who sell, solicit, or negotiate credit insurance on its behalf prior to allowing these employees to sell, solicit, or negotiate such insurance. The Commissioner shall approve materials for this training course in a manner provided for by rules and regulations. The entity shall maintain records of compliance with this subparagraph and shall submit such records upon the Commissioner's request;

(C) The entity provides at least two hours of annual continuing education courses taught by such entity or an insurer to its employees who sell, solicit, or negotiate credit insurance on its behalf. The Commissioner shall approve materials for this training course by rules and regulations. Such entity shall maintain records of compliance with this subparagraph and shall submit such records upon the request of the Commissioner;

(D) The entity submits to the Commissioner along with its application for licensure a list of employees who sell, solicit, or negotiate credit insurance on behalf of the entity in a manner prescribed by the Commissioner. Such entity shall update such employee list in a manner prescribed by the Commissioner; and

(E) The entity submits to the Commissioner with its application for licensure a list of all physical locations where its employees sell, solicit, or negotiate credit insurance on its behalf. The entity shall update such list in a manner prescribed by the Commissioner.

(2) The entity shall make application to the Commissioner for a limited credit insurance agency license in such form or forms and providing such information as the Commissioner may prescribe and shall pay an initial license fee pursuant to Code Section 33-8-1 or as provided for by rules and regulations.

(3) The lines or sublines of insurance included in the scope of authority of limited credit insurance agency licenses issued under this subsection shall include such licenses as provided for in paragraph (5) of subsection (b) of this Code section.

(4) Any limited credit insurance agency license issued under this subsection shall also authorize any employee of such limited licensee to act individually on behalf and under the supervision of such limited licensee with respect to selling, soliciting, and negotiating the

kinds of coverage specified in this subsection only and any such employee shall be authorized to receive related compensation, notwithstanding any other provision of law.

(5) In the event that any provision of this title is violated by a limited licensee or any employee selling, soliciting, or negotiating credit insurance on behalf of such limited licensee, the Commissioner may:

(A) Revoke, suspend, or place on probation the entity's limited credit insurance agency license issued under this subsection in accordance with the provisions of Code Sections 33-23-21 and 33-23-22, and the procedures for notice and the conduct of hearings pursuant to Chapter 2 of this title; or

(B) Impose such other penalties, including but not limited to suspending the transaction of insurance at specific locations where violations of this subsection have occurred as the Commissioner determines to be necessary or convenient to carry out the purposes of this subsection in accordance with the procedures for notice and the conduct of hearings set forth in Chapter 2 of this title.

(6) An appeal from any order or decision of the Commissioner made pursuant to this subsection shall be conducted pursuant to Chapter 2 of this title.

(7) Limited credit insurance agency licenses issued pursuant to this Code section shall renew biennially on December 31 of the applicable renewal year. The entity shall make application for renewal to the Commissioner for such licenses in such form or forms and containing such information required by the Commissioner and shall pay a renewal license fee pursuant to Code Section 33-8-1 and rules and regulations.

(c)(1) As used in this subsection, the term:

(A) "Limited licensee" means a person or entity authorized to sell certain coverages relating to the rental of vehicles pursuant to the provisions of this subsection.

(B) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

(C) "Rental company" means any person or entity in the business of providing primarily private passenger vehicles to the public under a rental agreement for a period not to exceed 90 days.

(D) "Rental period" means the term of the rental agreement.

(E) "Renter" means any person obtaining the use of a vehicle

from a rental company under the terms of a rental agreement for a period not to exceed 90 days.

(F) "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type, including passenger vans, minivans, and sport utility vehicles, and of the cargo type, including cargo vans, pick-up trucks, and trucks with a gross vehicle weight of less than 26,000 pounds and which do not require the operator to possess a commercial driver's license.

(2) The Commissioner may issue to a rental company that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with the rental of vehicles.

(3) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(4) In the event that any provision of this subsection is violated by a limited licensee, the Commissioner may:

(A) After notice and a hearing, revoke or suspend a limited license issued under this subsection in accordance with the provisions of Code Sections 33-23-21 and 33-23-22; or

(B) After notice and a hearing, impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations of this subsection have occurred, as the Commissioner deems to be necessary or convenient to carry out the purposes of this subsection.

(5) The rental company licensed pursuant to paragraph (2) of this subsection may only offer or sell insurance through licensed insurers in connection with and incidental to the rental of vehicles, whether at the rental office or by preselection of coverage in an individual, master, corporate, or group rental agreement, in any of the following general categories:

(A) Personal accident insurance covering the risks of travel, including, but not limited to, accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period;

(B) Liability insurance, which, at the exclusive option of the rental company, may include uninsured and underinsured motorist coverage, whether offered separately or in combination with other

liability insurance, that provides coverage, as applicable, to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle;

(C) Personal effects insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for the loss of, or damage to, personal effects that occurs during the rental period;

(D) Roadside assistance and emergency sickness protection programs; and

(E) Any other travel or vehicle related coverage that a rental company offers in connection with and incidental to the rental of vehicles.

(6) No insurance shall be offered by a limited licensee pursuant to this subsection unless:

(A) The rental period of the rental agreement does not exceed 90 consecutive days;

(B) At every rental location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

(i) Summarize clearly and correctly the material terms of coverage offered to renters, including the identity of the insurer;

(ii) Disclose that such policies offered by the rental company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(iii) State that the purchase by the renter of the kinds of coverage specified in this subsection is not required in order to rent a vehicle; and

(iv) Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim; and

(C) Evidence of coverage on the face of the rental agreement is disclosed to every renter who elects to purchase such coverage.

(7) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(8) Each rental company licensed pursuant to this subsection shall provide a training program in which employees being trained by an

instructor licensed under this article receive basic insurance instruction about the kinds of coverage specified in this subsection and offered for purchase by prospective renters of rental vehicles. Additionally, each rental company shall provide for such employees two hours of continuing education courses annually to be taught by an instructor licensed under this article. A rental company shall certify that, prior to offering such coverages, each employee has received such instruction.

(9) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee pursuant to this subsection shall not be required to treat moneys collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental transaction. The sale of insurance not in conjunction with a rental transaction shall not be permitted.

(10) No limited licensee under this subsection shall advertise, represent, or otherwise hold itself or any of its employees out as licensed insurers, insurance agents, or insurance brokers.

(d)(1) As used in this subsection, the term:

(A) "Customer" means a person who purchases portable electronics or services.

(B) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(C) "Location" means any physical location in this state or any website, call center site, or similar location directed to residents of this state.

(D) "Portable electronics" means handsets, pagers, personal digital assistants, portable computers, automatic answering devices, cellular telephones, batteries, and other similar devices and their accessories and includes services related to the use of such devices, including, but not limited to, individual customer access to a wireless network.

(E) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following: loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss. Such term shall not include a service contract or extended warranty providing coverage limited to the repair, replacement, or maintenance of property in cases of operational or structural failure due to

a defect in materials, workmanship, accidental damage from handling power surges, or normal wear and tear.

(F) "Portable electronics transaction" means the sale or lease of portable electronics by a vendor to a customer or the sale of a service related to the use of portable electronics by a vendor to a customer.

(G) "Supervising entity" means a business entity that is a licensed insurer, or insurance producer that is authorized by a licensed insurer, to supervise the administration of a portable electronics insurance program.

(H) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(2) The Commissioner may issue to a retail vendor of portable electronics that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell portable electronics insurance policies.

(3) A limited license issued under this subsection shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to customers at each location where the vendor engages in portable electronics transactions.

(4) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the Commissioner and with ten days' notice to the supervising entity, the registry shall be open to inspection and examination by the Commissioner during regular business hours of the supervising entity.

(5) The sale of such insurance policies shall be limited to sales in connection with the sale of or provision of service for portable electronics by the retail vendor.

(6) At every location where portable electronics insurance is offered to customers, brochures or other written materials shall be made available to a prospective customer which:

(A) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(B) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the coverage; and

(v) Key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with a similar make and model or with reconditioned or nonoriginal manufacturer parts or equipment;

(C) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(D) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

(7) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers. Coverage under portable electronics insurance shall be primary to any other insurance.

(8) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

(9) Notwithstanding any other provision of law, employees or authorized representatives of a vendor of portable electronics shall not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage but may receive compensation for activities under the limited license which are incidental to their overall compensation.

(10) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services, shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in an alternative

manner and remits such amounts to the supervising entity within 60 days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

(11) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for such limited license or licenses in a form and manner prescribed by the Commissioner. The application shall provide:

(A) The name, residence address, and other information required by the Commissioner of an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this subsection;

(B) If the vendor derives more than 50 percent of its revenue from the sale of portable electronics insurance, the information required by subparagraph (A) of this paragraph for all officers, directors, and shareholders of record having beneficial ownership of 10 percent or more of any class of securities registered under the federal securities law; and

(C) The location of the applicant's home office.

(12) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this Code section, provided that the supervising entity supervises the administration of a training program in which employees and authorized representatives of a vendor shall be trained and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective purchasers. The training required by this subsection may be provided in electronic form. However, if provided in electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance that is conducted and overseen by an instructor licensed under this article.

(13) No prelicensing examination shall be required for issuance of such license.

(14) If a vendor or its employee or authorized representative violates any provision of this subsection, the Commissioner may impose any of the following penalties:

(A) After notice and hearing, fines not to exceed $500.00 per violation or $5,000.00 in the aggregate for such conduct;

(B) After notice and hearing, other penalties that the Commis-

sioner deems necessary and reasonable to carry out the purpose of this article, including:

(i) Suspending the privilege of transacting portable electronics insurance pursuant to this subsection at specific business locations where violations have occurred; and

(ii) Suspending or revoking the ability of individual employees or authorized representatives to act under the license;

(15) Notwithstanding any other provision of law:

(A) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least 60 days' notice;

(B) If the insurer changes the terms and conditions, then such insurer shall provide the vendor with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of such changes;

(C) Notwithstanding subparagraph (A) of this paragraph, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 15 days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim;

(D) Notwithstanding subparagraph (A) of this paragraph, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(i) For nonpayment of premium;

(ii) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(iii) If the enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer; and

(E) When a portable electronics insurance policy is terminated by a policyholder, the vendor shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the

termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least 30 days prior to the termination.

(16) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this subsection or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means as set forth in this paragraph. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's email address specified for such purpose and to its affected enrolled customers' last known email address as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be. For purposes of this paragraph, an enrolled customer's provision of an email address to the insurer or vendor of portable electronics, as the case may be, shall be deemed as consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice or correspondence was sent.

(17) Notice or correspondence required by this subsection or otherwise required by law may be sent on behalf of an insurer or vendor, as the case may be, by the supervising entity appointed by the insurer.

(e)(1) As used in this subsection, the term:

(A) "Limited licensee" means an owner authorized to act as an agent of an insurance provider for purposes of selling certain insurance coverages for personal property maintained in self-service storage facilities pursuant to this subsection.

(B) "Occupant" means a person, his or her sublessee, successor, or assign entitled to the use of the storage space at a self-service storage facility under a rental agreement, to the exclusion of others.

(C) "Owner" means the owner, operator, lessor, or sublessor of a self-service storage facility, his or her agent, or any other person

authorized by him or her to manage the self-service storage facility or to receive rent from an occupant under a rental agreement.

(D) "Personal property" means movable property not affixed to land and includes, but is not limited to, goods, wares, merchandise, motor vehicles, watercraft, and household items and furnishings.

(E) "Rental agreement" means any agreement or lease, written or oral, that establishes or modifies the terms, conditions, rules, or any other provisions concerning the use and occupancy of a self-service storage facility.

(F) "Self-service storage facility" means any real property designed and used for the purpose of renting or leasing individual storage space to occupants who are to have access to such for the purpose of storing and removing personal property. No occupant shall use a self-service storage facility for residential purposes. A self-service storage facility is not a warehouse within the meaning of Article 1 of Chapter 4 of Title 10, the "Georgia State Warehouse Act." A self-service storage facility is not a safe-deposit box or vault maintained by banks, trust companies, or other financial entities.

(2) The Commissioner may issue to an owner that is in compliance with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with a self-service storage facility.

(3) A limited licensee shall be authorized to offer or sell insurance on behalf of a licensed insurer only in connection with a rental agreement and only for either an individual policy issued to an individual occupant or as a group policy for occupants for personal property insurance. A limited licensee shall only be authorized to provide to occupants insurance coverage for:

(A) The loss of or damage to personal property stored at a self-service storage facility where the loss or damage occurs at such self-service storage facility during the occupant's rental agreement; or

(B) Such other loss directly related to an occupant's rental agreement.

(4) No insurance shall be issued pursuant to this subsection unless the limited licensee provides to a prospective occupant written material that:

(A) Provides a summary of the terms of insurance coverage, including the identity of the insurer;

(B) Conspicuously discloses that the policy of insurance may provide a duplication of coverage already provided by an existing policy of insurance;

(C) Describes the process for filing a claim in the event the occupant elects to purchase coverage and experiences a covered loss;

(D) Provides information regarding the price, deductible, benefits, exclusions, conditions, and any other limitations of such policy;

(E) States that the limited licensee is not authorized to evaluate the adequacy of the occupant's existing insurance coverages, unless such limited licensee is otherwise licensed; and

(F) States that the occupant may cancel the insurance at any time, and any unearned premium will be refunded in accordance with applicable law.

(5) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee licensed pursuant to this subsection shall not be required to treat moneys collected from occupants under rental agreements as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental agreement. The sale of insurance not in conjunction with a rental agreement shall not be permitted.

(6) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(7) Each owner licensed pursuant to this subsection shall provide a training program in which employees and authorized representatives of such owner shall be trained by an instructor licensed pursuant to this article and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective occupants.

(8) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(9) In the event that any provision of this title is violated by a limited licensee, or an employee of a limited licensee, the limited licensee shall be subject to all penalties, fines, criminal sanctions, and other actions authorized by this title.

(10) No prelicensing examination shall be required for issuance of a limited license pursuant to this subsection.

(f)(1) As used in this subsection, the term:

(A) "Aggregator site" means a website that provides access to

information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

(B) "Blanket travel insurance" means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group.

(C) "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. Such term shall not be considered insurance.

(D) "Eligible group" means two or more persons that are engaged in a common enterprise or have an economic, educational, or social affinity or relationship, including but not limited to any of the following:

(i) Any entity engaged in the business of providing travel or travel services, including but not limited to:

(I) Tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, travel agencies, property managers, or cultural exchange programs; or

(II) Common carriers or the operator, owner, or lessor of a means of transportation of passengers, including but not limited to airlines, cruise lines, railroads, steamship companies, and public bus carriers,

wherein, with regard to any particular travel or type of travel or travelers, all members or customers of the group share a common exposure to risk attendant to such travel;

(ii) Any college, school, or other institution of learning covering students, teachers, employees, or volunteers;

(iii) Any employer covering any group of employees, volunteers, contractors, board of directors, dependents, or guests;

(iv) Any sports team, camp, or sponsor thereof covering participants, members, campers, employees, officials, supervisors, or volunteers;

(v) Any religious, charitable, recreational, educational, or civic organization or branch thereof covering any group of members, participants, or volunteers;

(vi) Any financial institution or financial institution vendor, or any parent holding company, trustee, or agent of or designated by one or more financial institutions or financial institution vendors, including account holders, credit card holders, debtors, guarantors, or purchasers;

(vii) Any incorporated or unincorporated association, including labor unions, that has a common interest, a constitution, and bylaws and that is organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association in covering its members;

(viii) Any trust or the trustees of a fund established, created, or maintained for the benefit of and for covering members, employees, or customers, subject to the Commissioner permitting the use of a trust and the state's premium tax provisions provided in Code Section 33-8-4 for one or more associations meeting the requirements of division (vii) of this subparagraph;

(ix) Any entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers;

(x) Any volunteer fire department, ambulance, rescue, police, court, first aid, civil defense, or other such volunteer group;

(xi) Any preschool, day-care institution for children or adults, or senior citizen club;

(xii) Any automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers as defined by their travel status on the rented or leased vehicles;

(xiii) The common carrier; the operator, owner, or lessor of a means of transportation; or the automobile or truck rental or leasing company that is the policyholder under a policy to which this subsection applies; and

(xiv) Any other group to which the Commissioner has determined that issuance of the policy would not be contrary to the public interest and in which the members are engaged in a common enterprise or have an economic, educational, or social affinity or relationship.

(E) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

(F) "Group travel insurance" means travel insurance issued to any eligible group.

(G) "Limited licensee" means a person or entity authorized to sell certain coverages related to travel pursuant to the provisions of this subsection.

(H) "Limited lines travel insurance producer" means a:

(i) Licensed managing general underwriter;

(ii) Licensed managing general agent or third-party administrator;

(iii) Licensed insurance producer, including a limited licensee; or

(iv) Travel administrator.

(I) "Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application and collecting premiums.

(J) "Primary certificate holder" means an individual or person that elects and purchases travel insurance under a group policy.

(K) "Travel administrator" means each person that directly or indirectly underwrites; collects charges, collateral, or premiums from; or adjusts or settles claims for residents of this state in connection with travel insurance; provided, however, that a person shall not be considered a travel administrator if such person's only actions that would otherwise cause it to be considered a travel administrator are among the following:

(i) An insurance producer selling insurance or engaged in administrative and claims related activities within the scope of the producer's license;

(ii) A travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer in accordance with this subsection;

(iii) An individual adjusting or settling claims in the normal course of such individual's practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage; or

(iv) A business entity that is affiliated with a licensed insurer while acting as a travel administrator for the direct and assumed insurance business of an affiliated insurer.

(L) "Travel assistance services" means:

(i) Noninsurance services for which the consumer is not indemnified based on a fortuitous event and the provision of the

service does not result in the transfer or shifting of risk that would constitute the business of insurance;

(ii) Such term shall include, but not be limited to, security advisories; destination information; vaccination and immunization information services; travel reservation services; entertainment; activity and event planning; translation assistance; emergency messaging; international legal and medical referrals; medical case monitoring; coordination of transportation arrangements; emergency cash transfer assistance; medical prescription replacement assistance; passport and travel document replacement assistance; lost luggage assistance; concierge services; and any similar service that is furnished in connection with planned travel; and

(iii) Such term shall not include assistance services that are insurance or related to insurance.

(M) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including:

(i) Interruption or cancellation of trip or event;

(ii) Loss of baggage or personal effects;

(iii) Damages to accommodations or rental vehicles;

(iv) Sickness, accident, disability, or death occurring during travel;

(v) Emergency evacuation;

(vi) Repatriation of remains; or

(vii) Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

Travel insurance shall not include major medical plans which provide comprehensive medical protection for travelers with trips lasting six months or longer, including, but not limited to, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license.

(N) "Travel protection plan" means any plan that provides for travel insurance, travel assistance services, or cancellation fee waivers.

(O) "Travel retailer" means a business entity that makes, arranges, or offers travel services and that may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

(2)(A) Notwithstanding any other provision of law, the Commissioner may issue to an individual or business entity that has complied with the requirements of this subsection a limited lines travel insurance producer license which authorizes the limited lines travel insurance producer to sell, solicit, or negotiate travel insurance through a licensed insurer.

(B) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for such limited license in a form and manner prescribed by the Commissioner.

(C) Notwithstanding any other provision of law, a travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if the following conditions are met:

(i) The limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

(I) A description of the material terms or the actual material terms of the insurance coverage;

(II) A description of the process for filing a claim;

(III) A description of the review or cancellation process for the travel insurance policy; and

(IV) The identity and contact information of the insurer and limited lines travel insurance producer;

(ii) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register on a form prescribed by the Commissioner of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf. The register shall be maintained and updated by the limited lines travel insurance producer and shall include the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations and the travel retailer's federal tax identification number. The limited lines travel insurance producer shall submit such register to the Insurance Department upon reasonable request. The limited lines travel insurance producer shall also certify that the travel retailer registered complies with 18 U.S.C. Section 1033. The grounds for the suspension and revocation and the penalties applicable to resident insurance providers shall be applicable to limited lines travel insurance producers and travel retailers;

(iii) The limited lines travel insurance producer shall designate one of its employees who is a licensed individual producer as

the person responsible for the limited lines travel insurance producer's compliance with the travel insurance laws and rules and regulations of this state;

(iv) The employee designated as provided in division (iii) of this subparagraph, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations shall comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer;

(v) The limited lines travel insurance producer shall pay all applicable insurance producer licensing fees as set forth in applicable state law;

(vi) The limited lines travel insurance producer shall require each employee or authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the Commissioner. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers; and

(vii) No prelicensing examination or continuing education shall be required for issuance of a limited license pursuant to this subsection.

(D) Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

(i) Provide the identity and contact information of the insurer and the limited lines travel insurance producer;

(ii) Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(iii) Explain that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(E) A travel retailer employee or authorized representative that is not licensed as an insurance producer shall not:

(i) Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(ii) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(iii) Hold itself out as a licensed insurer, licensed producer, or insurance expert.

(3) Notwithstanding any other provision of law, a travel retailer whose insurance related activities, and those of its employees or authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this subsection shall be authorized to do so and receive related compensation upon registration by the limited lines travel insurance producer as provided in subparagraph (C) of paragraph (2) of this subsection.

(4) As the insurer designee, the limited lines travel insurance producer shall be responsible for the acts of the travel retailer and authorized representative and shall use reasonable means to ensure compliance by the travel retailer with this subsection.

(5) The limited lines travel insurance producer and any travel retailer or authorized representative offering and disseminating travel insurance under the limited lines travel insurance producer's license shall be subject to the unfair trade practices provisions under Article 1 of Chapter 6 of this title and to the other provisions of this article relating to insurance producers.

(6)(A) The requirements of this subsection shall apply to travel insurance which covers any resident of this state; is sold, solicited, negotiated, or offered in this state; or for which policies and certificates are delivered or issued for delivery in this state; provided, however, that such requirements shall not apply to cancellation fee waivers and travel assistance services, except as expressly provided in this subsection.

(B) All other applicable provisions of the state's insurance laws shall continue to apply to travel insurance except that the specific provisions of this subsection shall supersede any general provisions of law that would otherwise be applicable to travel insurance.

(7) Any person licensed in a major line of authority as an insurance producer shall be authorized to sell, solicit, and negotiate travel insurance. A property and casualty insurance producer shall not be required to become appointed by an insurer in order to sell, solicit, or negotiate travel insurance.

(8)(A) Each travel insurer shall pay the tax levied by Code Section 33-8-4 with respect to travel insurance premiums paid by any of the following:

(i) An individual primary policyholder who is a resident of this state;

(ii) A primary certificate holder who is a resident of this state who elects coverage under a group travel insurance policy; or

(iii) A blanket travel insurance policyholder that is a resident in or has its principal place of business or the principal place of business of an affiliate or subsidiary that has purchased blanket travel insurance in this state for eligible blanket group members, subject to any apportionment rules which apply to the insurer across multiple taxing jurisdictions or that permits the insurer to allocate premiums on an apportioned basis in a reasonable and equitable manner in such jurisdictions.

(B) Each travel insurer shall:

(i) Document the state of residence or principal place of business of the policyholder or certificate holder, as described in subparagraph (A) of this paragraph; and

(ii) Report as premiums only the amount allocable to travel insurance and shall not report any amounts received for travel assistance services or cancellation fee waivers.

(9) A travel protection plan may be offered for one price for the combined features that the travel protection plan offers in this state if:

(A) The travel protection plan clearly discloses to the consumer at or prior to the time of purchase that it includes travel insurance, travel assistance services, and cancellation fee waivers, as applicable, and provides information and an opportunity at or prior to the time of purchase for the consumer to obtain additional information regarding the features and pricing of each; and

(B) The fulfillment materials:

(i) Describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan; and

(ii) Include the travel insurance disclosures and the contact information for persons providing travel assistance services and cancellation fee waivers, as applicable.

(10)(A) Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is considered an unfair trade practice under Chapter 6 of this title.

(B)(i) All documents provided to consumers prior to the purchase of travel insurance, including but not limited to sales materials,

advertising materials, and marketing materials, shall be consistent with the travel insurance policy itself, which shall include but not be limited to respective forms, endorsements, policies, rate filings, and certificates of insurance.

(ii) For travel insurance policies or certificates that contain preexisting condition exclusions, information and an opportunity to learn more about the preexisting condition exclusions shall be provided at some point prior to the time of purchase and in the coverage's fulfillment materials.

(iii) The fulfillment materials and the information described in division (f)(2)(c)(i) of this Code section shall be provided to a policyholder or primary certificate holder as soon as practicable following the purchase of a travel protection plan. Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or primary certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until at least:

(I) Fifteen days following the date of delivery of the travel protection plan's fulfillment materials by postal mail; or

(II) Ten days following the date of delivery of the travel protection plan's fulfillment materials by means other than postal mail.

For the purposes of this division, the term "delivery" means handing fulfillment materials to the policyholder or primary certificate holder or sending fulfillment materials by postal mail or electronically to the policyholder or primary certificate holder.

(iv) Each company shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

(v) If travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it shall not be considered an unfair trade practice or other violation of law if an accurate summary or short description of coverage is provided on the website, so long as the consumer has electronic access to the full provisions of the policy.

(C) A person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis shall not do so by using negative option or opt out that would require a consumer to take an affirmative action to deselect coverage such as unchecking a box on an electronic form when the consumer purchases a trip.

(D) It shall be considered an unfair trade practice to market blanket travel insurance coverage as being free.

(E) If a consumer's destination jurisdiction requires insurance coverage, it shall not be considered an unfair trade practice to require such consumer to choose between the following options as a condition of purchasing a trip or travel package:

(i) Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer supplying the trip or travel package; or

(ii) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

(11)(A) Notwithstanding any provision of this title to the contrary, a person shall not act or represent itself as a travel administrator for travel insurance in this state unless such person:

(i) Is a licensed property and casualty insurance producer in this state for activities permitted under such producer's license;

(ii) Holds a valid managing general agent (M.A.) license in this state; or

(iii) Holds a valid third-party administrator (TA) license in this state.

(B) A travel administrator and its employees shall be exempt from the licensing requirements provided in paragraph (4) of subsection (a) of Code Section 33-23-4, relating to adjuster licensing, for travel insurance that such travel administrator and its employees administer.

(C) An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer and ensuring that the travel administrator maintains all books and records relevant to the insurer to be made available by the travel administrator to the Commissioner upon request.

(12)(A) Notwithstanding any provision of this title to the contrary, travel insurance shall be classified and filed for purposes of rates and forms as marine and transportation insurance; provided, however, that travel insurance that provides coverage for sickness, accident, disability, or death occurring during travel, either exclusively or in conjunction with related coverages of emergency evacuation or repatriation of remains, or incidental limited property and casualty benefits, such as baggage or trip cancellation, may be filed by an authorized insurer under either an accident and health line of insurance or as marine and transportation insurance.

(B) Travel insurance may be in the form of an individual, group, or blanket policy.

(C) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels, provided that those standards also meet the state's underwriting standards for marine and transportation insurance.

History.
Code 1981, § 33-23-12, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1995, p. 437, § 3; Ga. L. 1999, p. 878, § 4; Ga. L. 2001, p. 4, § 33; Ga. L. 2001, p. 925, § 1; Ga. L. 2002, p. 1047, § 1; Ga. L. 2008, p. 1076, § 7/SB 113; Ga. L. 2012, p. 757, § 1/HB 463; Ga. L. 2012, p. 1040, §§ 2, 3/SB 203; Ga. L. 2012, p. 1350, §§ 1, 2/HB 1067; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2013, p. 742, §§ 1, 2/SB 234; Ga. L. 2014, p. 866, § 33/SB 340; Ga. L. 2017, p. 774, § 33/HB 323; Ga. L. 2018, p. 1081, § 1/HB 938; Ga. L. 2019, p. 337, § 1-93/SB 132; Ga. L. 2019, p. 386, § 7/SB 133; Ga. L. 2019, p. 1056, § 33/SB 52; Ga. L. 2020, p. 493, § 33/SB 429; Ga. L. 2021, p. 349, § 2/HB 205.

Amendments.
The 2021 amendment, effective May 4, 2021, rewrote subsection (f).

33-23-14. Probationary licenses.

(a) The Commissioner shall have the authority to issue a probationary license to any applicant under this chapter.

(b) A probationary license may be issued for a period of not less than three months and not longer than 24 months and shall be subject to immediate revocation for cause at any time without a hearing.

(c) The Commissioner, at his or her discretion, shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period.

History.
Code 1981, § 33-23-14, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2023, p. 542, § 2/HB 222, effective May 3, 2023.

Amendments.
The 2023 amendment, effective May 3, 2023, substituted "24 months" for "12 months" in subsection (b).

33-23-21.1. Licensing for educational borrowers in default.

The Commissioner shall not refuse to issue nor suspend or revoke a license of an applicant for or holder of a license because he or she has been certified by any entity of the federal government for nonpayment or default or breach of a repayment or service obligation under any federal educational loan, loan repayment, or service conditional scholarship program.

History.
Code 1981, § 33-23-21.1, enacted by Ga. L. 2019, p. 462, § 1-9/SB 214; Ga. L. 2024, p. 120, § 2-34/HB 985, effective June 30, 2024.
Amendments.
The 2024 amendment, effective June 30, 2024, deleted "is a borrower in default under the Georgia Higher Education Loan Program as determined by the Georgia Higher Education Assistance Corporation or".

33-23-23. Limitation on application after refusal or revocation of license; effect of surrender of license under written consent order.

(a) No licensee or applicant whose license or application has been refused or revoked as provided by Code Sections 33-23-21 and 33-23-22 shall be entitled to file another application for a license as an agent, agency, limited subagent, surplus lines broker, counselor, or adjuster within five years from the effective date of the refusal, revocation, or, if judicial review of such refusal or revocation is sought, within five years from the date of the final court order or decree affirming such refusal or revocation.

(b) The application when filed may be refused by the Commissioner unless the applicant shows good cause why the refusal or revocation of the license shall not be deemed a bar to the issuance of a new license.

(c) Any surrender of a license under written consent order shall have the same effect as a revocation under subsections (a) and (b) of this Code section.

(d) At the Commissioner's discretion, an applicant whose application was refused under subsection (a) or (b) of this Code section may be permitted to file an application for a license; provided, however, that such application shall be filed no less than one year from the effective date of the refusal.

History.
Code 1981, § 33-23-23, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 1997, p. 1296, § 9; Ga. L. 2001, p. 925, § 1; Ga. L. 2008, p. 1076, § 12/SB 113; Ga. L. 2019, p. 386, § 10/SB 133; Ga. L. 2023, p. 542, § 3/HB 222, effective May 3, 2023.
Amendments.
The 2023 amendment, effective May 3, 2023, added subsection (d).

33-23-43. Authority of adjusters; penalty for violation.

(a) An adjuster licensed as both an independent and a public adjuster shall not represent both the insurer and the insured in the same transaction.

(b) An adjuster shall have authority under his or her license only to investigate, settle, or adjust and report to his or her principal upon claims arising under insurance contracts on behalf of insurers only if

licensed as an independent adjuster or on behalf of insureds only if licensed as a public adjuster.

(c) No public adjuster, at any time, shall knowingly:

(1) Misrepresent to an insured that he or she is required to hire an independent or public adjuster to help the insured meet his or her obligations under his or her policy;

(2) Accept or agree to accept any money or other compensation from an attorney or any person acting on behalf of an attorney which the adjuster knows or should reasonably know is payment for the suggestion or advice by the adjuster to seek the services of the attorney or for the referral of any portion of a person's claim to the attorney;

(3) Hire or procure another to do any act prohibited by this subsection;

(4) Advertise or promise to pay or rebate all or any portion of any insurance deductible as an inducement to the sale of goods or services. As used in this paragraph, the term "promise to pay or rebate" includes:

(A) Granting any allowance or offering any discount against the fees to be charged, including, but not limited to, an allowance or discount in return for displaying a sign or other advertisement at the insured's premises; or

(B) Paying the insured or any person directly or indirectly associated with the claim any form of compensation, gift, prize, bonus, coupon, credit, referral fee, or other item of monetary value for any reason;

(5) Misrepresent to a claimant that he or she is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or as an independent adjuster, unless appointed by an insurer in writing to act on the insurer's behalf for that specific claim or purpose. A licensed public adjuster shall not charge a claimant a fee for adjusting a claim when he or she is appointed by the insurer for that specific claim or purpose and the appointment is accepted by the public adjuster;

(6) Solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence as defined in the insured's insurance contract;

(7) Have a direct or indirect financial interest in any aspect of a claim other than the salary, fee, commission, or other consideration established in a written contract with the insured which shall incorporate all of the conditions and provisions set out in Code Section 33-23-43.2;

(8) Charge to or collect from an insured any amount, other than reasonable compensation for services rendered based on time spent and expenses incurred, in any transaction where the insurer either pays or commits in writing to pay the policy limit or limits for all coverage under the insured's policy within three business days after the loss is reported to the insurer;

(9) Misrepresent to an insured or insurer that he or she is an attorney authorized by law to provide legal advice and services or that a policy covers a loss or losses outside the scope of the coverage provided by the insurance contract;

(10) Permit an unlicensed employee or representative of the adjuster to conduct business for which a license is required; or

(11) Hire or procure another to do any act prohibited by this subsection.

(d) For purposes of subsection (c) of this Code section, the term "public adjuster" shall include licensed public adjusters as defined by Code Section 33-23-1, persons representing themselves to be public adjusters who are not properly licensed by the Commissioner, and persons committing any act under paragraph (4) of subsection (c) of this Code section.

(e) Any person who violates any provision of subsection (c) of this Code section shall be guilty of a misdemeanor and such violation shall be grounds for suspension or revocation of licenses under this chapter.

(f) The Commissioner may adopt reasonable and necessary rules to implement this article, including but not limited to rules regarding:

(1) The qualifications for adjusters, in addition to those prescribed by this article, that are necessary to promote the public interest;

(2) The regulation of the conduct of adjusters, in accord with this article;

(3) The prescription of fees not prescribed elsewhere in this title that are necessary to cover the cost of filings or other administrative costs; and

(4) The regulation of advertisements and the definition of "advertisement" as the term is used in paragraph (4) of subsection (c) of this Code section.

History.

Code 1981, § 33-23-43, enacted by Ga. L. 1992, p. 2830, § 1; Ga. L. 2001, p. 925, § 1; Ga. L. 2011, p. 613, § 2/HB 423; Ga. L. 2014, p. 181, § 4/HB 610; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2019, p. 386, § 19/SB 133; Ga. L. 2021, p. 365, § 1/HB 254.

Amendments.

The 2021 amendment, effective July 1, 2021, substituted "Code Section 33-23-43.2" for "Code Section 33-23-43.1" at the

end of paragraph (c)(7) and added subsection (f).

Law reviews.

For annual survey on insurance, see 74 Mercer L. Rev. 137 (2022).

33-23-43.1. Representing oneself as public adjuster; when license not required.

(a) No person may act or hold himself or herself out to be a public adjuster in this state unless such person holds a public adjuster license issued by the Commissioner.

(b) A public adjuster license is not, however, required for:

(1) An attorney licensed to practice law in this state while acting for an insured concerning a loss under a policy; or

(2) A person licensed as a general property and casualty agent or personal lines property and casualty agent while acting for an insurer concerning a loss under a policy issued by that agent.

History.

Code 1981, § 33-23-43.1, enacted by Ga. L. 2021, p. 365, § 2/HB 254.

Effective date.

This Code section became effective July 1, 2021.

Editor's notes.

Ga. L. 2021, p. 365, § 1/HB 254, effective January 1, 2022, redesignated former Code Section 33-23-43.1, relating to requirements for public adjuster contracts, as present Code Section 33-23-43.2.

33-23-43.2. Requirements for public adjuster contracts.

(a) No person may, directly or indirectly, act within this state as a public adjuster without, among other requirements, having first entered into a contract, in writing, on a form approved by the Commissioner, executed in duplicate by such person and the insured or the insured's duly authorized representative. A public adjuster shall not use any form of contract that is not approved by the Commissioner.

(b) Public adjusters shall ensure that all contracts for their services are in writing, prominently captioned and titled "Public Adjuster Contract," and contain the following:

(1) Legible full name of the public adjuster signing the contract, as specified on the license issued by the department and attestation language that the public adjuster is fully bonded pursuant to state law;

(2) Permanent home state business address and contact information of the public adjuster, including email address;

(3) The public adjuster's department license number and a statement that the license is valid and in full force and effect as of the date the contract is signed;

(4) The insured's full name and street address;

(5) A description of the loss and its location, if applicable;

(6) A description of services to be provided to the insured;

(7) Signatures of the public adjuster and the insured;

(8) The date the contract was signed by the public adjuster, and the date the contract was signed by the insured;

(9) A statement of the fee, compensation, or other considerations that the public adjuster is to receive for services, including a listing of typical costs and expenses for which the public adjuster is to be reimbursed;

(10) A statement prominently captioned in a minimum 12 point font indicating that the public adjuster has no direct or indirect interest, including participation in activities that may be reasonably construed as a conflict of interest or as compensation by or interest in, any firm that performs any work in conjunction with the damages incident to any loss the public adjuster has been contracted to adjust, except for the compensation or fee from the insured for such public adjuster's services; and

(11) A prominently displayed notice in 12-point boldface type that states "WE REPRESENT THE INSURED ONLY."

(c) Public adjuster contracts may not contain a contract term that:

(1) Restricts an insured's right to initiate and maintain direct communications with his or her attorney, the insurer, the insurer's adjuster, the insurer's attorney, or any other person regarding settlement of the insured's claim;

(2) Vests the public adjuster with the right to initiate direct communications with the insured's insurer, the insurer's adjuster, or the insurer's attorney regarding settlement of the insured's claim without specific written authorization from the insured;

(3) Allows the public adjuster's percentage fee to be collected when money is due from an insurance company but not paid or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company rather than as a percentage of each check issued by an insurance company;

(4) Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster;

(5) Precludes or restricts an insured from pursuing any civil remedies relating to his or her claim;

(6) Purports to allow the public adjuster to act in multiple capacities; or

(7) Identifies the public adjuster as also being a contractor, appraiser, or other position.

(d) All public adjuster contracts shall be construed to contain, by operation of law:

(1) A provision granting the insured a right to rescind the contract within three business days after the date the contract was signed, so long as the rescission is in writing and mailed or delivered to the public adjuster at the address stated in the contract within three business days. For purposes of this subsection, rescission of the contract shall be considered delivered or mailed if it is delivered by electronic transmittal to the email address or facsimile specified in the contract for such communications;

(2) A provision that if the insured exercises the right to rescind the contract, anything of value given by the insured under the contract shall be returned to the insured within 15 business days following the receipt by the public adjuster of the rescission notice; and

(3) A provision requiring that, prior to initiating any contact with the insured's insurer, the insurer's adjuster, or the insurer's attorney regarding settlement of the insured's claim, a public adjuster must provide the insurer a notification letter signed by the insured confirming that the insured has authorized the public adjuster to communicate directly with the insurer, the insurer's adjuster, or the insurer's attorney on behalf of the insured.

(e) All public adjuster contracts shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the department.

(f) No public adjuster shall enter into a contract with an insured and collect a commission as provided by Code Section 33-23-43.3, without having the intent to actually perform services customarily provided by a public adjuster for the insured.

History.

Code 1981, § 33-23-43.1, enacted by Ga. L. 2014, p. 181, § 5/HB 610; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2019, p. 386, § 20/SB 133; Ga. L. 2020, p. 493, § 33/SB 429; Code 1981, § 33-23-43.2, as redesignated by Ga. L. 2021, p. 365, § 3/HB 254; Ga. L. 2023, p. 542, § 4/HB 222, effective May 3, 2023.

Amendments.

The 2021 amendment, effective July 1, 2021, redesignated former Code Section 33-23-43.1 as this Code section; added subsection (a); redesignated former sub-

sections (a) through (d) as present subsections (b) through (e), respectively; in subsection (b), substituted "department" for "Department of Insurance," in paragraph (b)(1) and substituted "department" for "Department of Insurance" in paragraph (b)(3), deleted "and" at the end of paragraph (b)(9), substituted "adjuster, as explicitly permitted by subsection (d) of Code Section 33-23-43.7; and" for "adjuster." at the end of subparagraph (b)(10)(C), and added paragraph (b)(11); in subsection (c), deleted "or" at the end of paragraph (c)(4), substituted a semicolon for a period at the end of paragraph (c)(5), and added paragraphs (c)(6) and (c)(7); in subsection (d), substituted "email address" for "e-mail address" near the end of paragraph (d)(1); in subsection (e), substituted "department" for "Commissioner of Insurance" at the end; and added subsection (f).

The 2023 amendment, effective May 3, 2023, rewrote paragraph (b)(10), which read: "A statement prominently captioned in a minimum 12 point font that contains the following:

"(A) Any direct or indirect interest in or compensation by any construction firm, salvage firm, building appraisal firm, storage company, or any other firm or business entity that performs any work in conjunction with damages incident to any loss which the adjuster has been contracted to adjust;

"(B) Any direct or indirect participation in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the adjuster or disclosure of any other activities that may be reasonably construed as a conflict of interest, including a financial interest in any salvage, repair, construction, or restoration of any business entity that obtains business in connection with any claims that the public adjuster has a contract or agreement to adjust; and

"(C) Any direct or indirect compensation of value in connection with an insured's specific loss other than compensation from the insured for service as a public adjuster, as explicitly permitted by subsection (d) of Code Section 33-23-43.7; and".

Editor's notes.

Ga. L. 2021, p. 365, § 5/HB 254, effective July 1, 2021, redesignated former Code Section 33-23-43.2, relating to standard of conduct for public adjusters, as present Code Section 33-23-43.9.

33-23-43.3. Compensation of adjusters; criteria for written endorsement of payment.

(a) Except as provided by subsection (b) of this Code section, an adjuster may receive a commission for service provided under this article consisting of an hourly fee, a flat rate, a percentage of the total amount paid by an insurer to resolve a claim, or another method of compensation. A public adjuster may not charge the insured an unreasonable fee, and the total commission received shall not exceed 33.3 percent of the amount of the insurance settlement of the claim.

(b) An adjuster shall not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim on a claim on which the insurer, not later than 72 hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy. A public adjuster is entitled to reasonable compensation from the insured for services provided by such adjuster on behalf of the insured, based on the time spent on a claim that is subject to this Code section and expenses incurred by such adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

(c) Except for the payment of a commission by the insured, all persons paying proceeds of a policy of insurance or making any payment affecting an insured's rights under a policy of insurance shall:

(1) Include the insured as a payee on the payment draft or check; and

(2) Require the written signature and endorsement of the insured on the payment draft or check.

(d) An adjuster shall not accept any payment that violates the provisions of this Code section.

(e) A public adjuster may sign or endorse a payment, draft, or check issued on behalf of an insured if authorized in writing by each insured payee, and only if such written endorsement meets the following criteria:

(1) The authorization limits the public adjuster to endorse the check or payment for deposit only into the public adjuster's escrow or trust account and such authorization states that the check or payment will be distributed in the percentages or amounts agreed upon in the public adjuster contract;

(2) The authorization requires that the insured be notified of the deposit of funds, and states that any distribution of such funds to the insured or the public adjuster will be accompanied by a detailed breakdown of the funds distributed; and

(3) The authorization form states that such authorization may be revoked at any time by the insured upon written notice of such revocation to the public adjuster.

History.
Code 1981, § 33-23-43.3, enacted by Ga. L. 2021, p. 365, § 4/HB 254.

Effective date.
This Code section became effective July 1, 2021.

33-23-43.4. Proof of financial responsibility.

(a) As a continuing condition of licensure, a public adjuster may, at the Commissioner's discretion, file proof of financial responsibility with respect to transactions with insureds under this chapter in an amount determined by the Commissioner by rule. The financial responsibility shall include the ability to pay sums that the public adjuster is obligated to pay under any judgment against such adjuster by an insured, based on an error, omission, fraud, negligent act, or unfair practice of such adjuster or any person for whose acts such adjuster is legally liable in the transaction of such adjuster's business under this Code section.

(b) In determining the amount of the financial responsibility require-

ment, the Commissioner shall consider the nature of the obligation, other financial security requirements under this Code section, and financial security requirements adopted for public adjusters in other states. In determining the types of financial responsibility required, the Commissioner may consider a surety bond or a professional liability policy or similar policy or contract of professional liability coverage acceptable to the Commissioner.

(c) The requirements of this Code section are in addition to the bond requirements of Code Section 33-23-6 and relevant rules and regulations promulgated by the Commissioner.

History.
Code 1981, § 33-23-43.4, enacted by Ga. L. 2021, p. 365, § 4/HB 254.

Effective date.
This Code section became effective July 1, 2021.

33-23-43.5. Complete record of transactions; retention and examination.

(a) A public adjuster shall keep a complete record in this state of each of such adjuster's transactions as a public adjuster. The records shall include each of the following:

(1) The name of the insured;

(2) The date, location, and amount of the loss;

(3) A copy of the contract between the public adjuster and the insured;

(4) The name of the insurer and the amount, expiration date, and number of each policy under which the loss is covered;

(5) An itemized statement of the recoveries by the insured from the sources known to the public adjuster;

(6) The total compensation received for the adjustment; and

(7) An itemized statement of disbursements made by the license holder from recoveries received on behalf of the insured.

(b) Records required to be kept under this Code section shall be:

(1) Maintained in this state for at least five years after the termination of a transaction with the insured; and

(2) Open to examination by the Commissioner.

History.
Code 1981, § 33-23-43.5, enacted by Ga. L. 2021, p. 365, § 4/HB 254.

Effective date.
This Code section became effective July 1, 2021.

33-23-43.6. Funds held in fiduciary capacity; authorization for disclosure.

(a) All funds received as claim proceeds by an adjuster acting as a public adjuster are received and held by such adjuster in a fiduciary capacity. Such adjuster shall not divert or misappropriate fiduciary funds received or held.

(b) An applicant for a license to act as a public adjuster shall, as part of the application, endorse an authorization for disclosure to the Commissioner of all financial records of any funds such adjuster holds and will hold as a fiduciary. The authorization continues in force and effect for as long as such adjuster continues to be licensed under this article.

History.
Code 1981, § 33-23-43.6, enacted by Ga. L. 2021, p. 365, § 4/HB 254.

Effective date.
This Code section became effective July 1, 2021.

33-23-43.7. Advertisements; deceptive or misleading ads; required disclaimer.

(a) Each advertisement by an adjuster soliciting or advertising business shall display the adjuster's name and license number as they appear in the records of the Commissioner.

(b) No advertisement soliciting or advertising business may be used by an adjuster unless such solicitation or advertisement has been approved by the Commissioner.

(c) The following statements, made in any public adjuster's advertisement or solicitation, are considered deceptive or misleading:

(1) A statement or representation that invites an insured to submit a claim when such insured does not have covered damage to such insured's property;

(2) A statement or representation that invites an insured to submit a claim by offering monetary or other valuable inducement;

(3) A statement or representation that invites an insured to submit a claim by stating that there is "no risk" to the insured by submitting such claim; and

(4) A statement or representation, or use of a logo or shield, that implies or could mistakenly be construed to imply that the solicitation was issued or distributed by a governmental agency or is sanctioned or endorsed by a governmental agency.

(d) For purposes of this subsection, the term "written advertisement" includes only newspapers, magazines, flyers, and bulk mailers. The

following disclaimer, which is not required to be printed on standard size business cards, shall be added in bold print and capital letters in typeface no smaller than the typeface of the body of the text to all written advertisements of a public adjuster:

"THIS IS A SOLICITATION FOR BUSINESS. IF YOU HAVE HAD A CLAIM FOR AN INSURED PROPERTY LOSS OR DAMAGE AND YOU ARE SATISFIED WITH THE PAYMENT BY YOUR INSURER, YOU MAY DISREGARD THIS ADVERTISEMENT".

History.
Code 1981, § 33-23-43.7, enacted by Ga. L. 2021, p. 365, § 4/HB 254.

Effective date.
This Code section became effective July 1, 2021.

33-23-43.8. Prohibited acts of adjusters.

(a) An adjuster shall not solicit or attempt to solicit a client for employment during the progress of a loss-producing natural disaster occurrence. For purposes of this subsection, the term "natural disaster" means any natural disaster for which a state of emergency is proclaimed by the Governor.

(b) An adjuster shall not solicit or attempt to solicit business on a loss or a claim in person, by telephone, or in any other manner at any time except between the hours of 8:00 A.M. and 10:00 P.M. on a weekday or a Saturday and between noon and 10:00 P.M. on a Sunday. This subsection shall not prohibit an adjuster from accepting phone calls or personal visits during the prohibited hours from an insured on the insured's initiation.

(c) An adjuster shall not knowingly make any false report to the adjuster's employer or client and shall not divulge to any other person, except as the law may require, any information obtained except at the direction of the employer or the client for whom the information is obtained.

(d) An adjuster shall not permit an unlicensed employee or other representative of the adjuster to in any manner conduct business for which a license is required under this chapter.

(e) An agent shall not render services or perform acts that constitute the practice of law, including the giving of legal advice to any person, in his or her capacity as an adjuster.

(f) A public adjuster shall not solicit or attempt to solicit business, directly or indirectly, or act in any manner on a bodily injury loss covered by a life, health, or accident insurance policy or on any claim for which the client is not an insured under the insurance policy.

(g) An adjuster shall not:

(1) Participate directly or indirectly in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by such adjuster;

(2) Engage in any other activities that may reasonably be construed as presenting a conflict of interest, including soliciting or accepting any remuneration from, having a financial interest in, or deriving any direct or indirect financial benefit from, any salvage firm, repair firm, construction firm, or other firm that obtains business in connection with any claim the adjuster has a contract or agreement to adjust;

(3) Without the knowledge and consent of the insured in writing, acquire an interest in salvaged property that is the subject of a claim adjusted by such adjuster;

(4) Represent an insured on a claim or charge a fee to an insured while representing the insurance carrier against which such claim is made;

(5) Directly or indirectly solicit employment for an attorney or enter into a contract with an insured for the primary purpose of referring an insured to an attorney without the intent to actually perform the services customarily provided by a licensed public adjuster. This Code section shall not be construed to prohibit an adjuster from recommending a particular attorney to an insured; or

(6) Act on behalf of an attorney during the course of a claim adjustment, through an insured signed attorney representation agreement or other means.

(h) An adjuster shall not engage in misrepresentation to solicit a contract or agreement to adjust a claim.

(i) An adjuster shall not:

(1) Advance money to any potential client or insured; or

(2) Pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, to a person who is not a licensed public adjuster a fee, commission, or other valuable consideration for the referral of an insured to such adjuster for purposes of the insured entering into a contract with such adjuster or for any related purpose.

(j) An adjuster shall not use any letterhead, advertisement, or other printed matter, or use any other means, to represent that such adjuster is an instrumentality of the federal government, of a state, or of a political subdivision of a state.

(k) A contractor shall not act as a public adjuster or advertise to adjust claims for any property for which the contractor is providing or may provide contracting services, regardless of whether the contractor:

(1) Holds a license under this chapter; or

(2) Is authorized to act on behalf of the insured under a power of attorney or other agreement. However, a contractor may discuss or explain a bid for construction or repair of covered property with a residential property owner who has suffered loss or damage covered by a property insurance policy, or the insurer of such property, if the contractor is doing so for the usual and customary fees applicable to the work to be performed as stated in the contract between the contractor and the insured.

(l) A public adjuster shall not accept a fee, commission, or other valuable consideration of any nature, regardless of form or amount, in exchange for the referral by such adjuster of an insured to any third-party individual or firm, including an attorney, appraiser, umpire, construction company, contractor, or salvage company.

(m) No person who has had his or her license under this title refused or revoked shall be an owner, officer, or director of a business entity, association, or corporation if such entity, association, or corporation holds itself out as a public adjuster, a public adjusting firm, or otherwise represents itself or acts as an association of public adjusters or an association which offers public adjusting services.

History.
Code 1981, § 33-23-43.8, enacted by Ga. L. 2021, p. 365, § 4/HB 254; Ga. L. 2022, p. 352, § 33/HB 1428.
Effective date.
This Code section became effective July 1, 2021.
Amendments.
The 2022 amendment, effective May 2, 2022, part of an Act to revise, modernize, and correct the Code, in subsection (b), substituted "8:00 A.M." for "8 A.M." and "10:00 P.M." for "10 P.M." twice; and revised punctuation at the end of paragraphs (g)(3) and (g)(4).

33-23-43.9. Standard of conduct for public adjusters.

(a) A public adjuster is obligated, under his or her license, to serve with objectivity and complete loyalty to the interest of his or her client alone and to render to the insured such information, counsel, and service within the public adjuster's knowledge, understanding, and opinion that will best serve the insured's insurance claim needs and interest.

(b) A public adjuster shall faithfully observe all of the terms and provisions of the public adjuster contract as prescribed in Code Section 33-23-43.2.

History.
Code 1981, § 33-23-43.2, enacted by Ga. L. 2014, p. 181, § 5/HB 610; Code 1981, § 33-23-43.9, as redesignated by Ga. L. 2021, p. 365, § 5/HB 254.
Amendments.
The 2021 amendment, effective July 1, 2021, redesignated former Code Section 33-23-43.2 as this Code section and substituted "Code Section 33-23-43.2" for

"Code Section 33-23-43.1" at the end of subsection (b).

33-23-43.10. Denial, suspension, or revocation of license; notice and hearing.

(a) The Commissioner may deny an application for a license or suspend or revoke a license issued to any public adjuster on the basis of:

(1) A violation of this article or of any rule adopted by the Commissioner under this article;

(2) A cause that constitutes grounds for denial of an original license;

(3) Misrepresentation or fraud in obtaining a license;

(4) The failure to pass a required license examination;

(5) The misappropriation or conversion of money required to be held in a fiduciary capacity;

(6) Material misrepresentation, with intent to deceive, of the terms of an insurance contract;

(7) Engaging in a fraudulent transaction;

(8) Demonstrating incompetence or untrustworthiness in the conduct of the license holder's affairs under the license, as determined by the Commissioner;

(9) Conviction of a felony by a final judgment in a court of competent jurisdiction; or

(10) Material misrepresentation, with intent to deceive, of the person's status as a public adjuster.

(b) If the department proposes to refuse to issue an original license under this article or to suspend, revoke, or refuse to renew a license under this article, the rejected applicant or affected licensee is entitled to a notice and hearing in accordance with Chapter 2 of this title.

History.
Code 1981, § 33-23-43.10, enacted by Ga. L. 2021, p. 365, § 6/HB 254.

Effective date.
This Code section became effective July 1, 2021.

CHAPTER 24

INSURANCE GENERALLY

Article 1

General Provisions

Sec.
33-24-14.1. Electronic delivery of plan documentation.
33-24-28. Termination of coverage of dependent child upon attainment of specified age.
33-24-28.1. Coverage of treatment of mental health or substance use disorders.
33-24-29. Coverage for treatment of mental disorders under accident and sickness insurance benefit plans providing major medical benefits covering small groups; federal law.
33-24-29.1. Coverage for mental disorders under accident and sickness insurance benefit plans providing major medical benefits covering all groups except small groups.
33-24-46. (Effective until January 1, 2026.) Cancellation or nonrenewal of certain property insurance policies.
33-24-46. (Effective January 1, 2026.) Cancellation or nonrenewal of certain property insurance policies.
33-24-56.4. Short title; definitions; payment for telehealth services.
Sec.
33-24-59.15. (Effective until January 1, 2026.) Definitions; dental insurance.
33-24-59.15. (Effective January 1, 2026.) Definitions; dental insurance; prohibited activities.
33-24-59.27. Right to shop for insurance coverage; disclosure of pricing information; notice.
33-24-59.30. Requirements for health insurance issuer for anatomical gifts or organ transplants; medically inappropriate organ transplants.
33-24-59.31. When a value-added product or service is not an unfair trade practice or unlawful inducement.
33-24-59.32. Cost-sharing requirements for diagnostic and supplemental breast screening examinations.
33-24-59.33. Required coverage for biomarker testing.
33-24-59.34. Required medical coverage for standard fertility preservation services.
33-24-59.35. Required coverage orthotic devices and prosthetic devices; reporting; regulation.
33-24-59.36. Required coverage for healthcare services for PANDAS or PANS.

ARTICLE 1

GENERAL PROVISIONS

33-24-3. Insurable interest; personal insurance.

JUDICIAL DECISIONS

One may insure own life and assign to another not having insurable interest.

Georgia Supreme Court answered the certified questions as follows: Under Georgia law, a life-insurance policy taken out by the insured on his own life with the intent to sell the policy to a third party with no insurable interest, but without a third party's involvement when the policy

was procured, is not void as an illegal wagering contract. Crum v. Jackson National Life Insurance Company, 315 Ga. 67, 880 S.E.2d 205, 2022 Ga. LEXIS 274 (2022).

33-24-14.1. Electronic delivery of plan documentation.

(a) As used in this Code section, the term:

(1) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a vision or dental benefit plan.

(2) "Plan sponsor" means a person, other than a regulated entity, who establishes, adopts, or maintains a health benefit plan that covers residents of this state, including a plan established, adopted, or maintained by an employer or jointly by an employer and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

(b) The plan sponsor of a health benefit plan may, on behalf of a covered person, consent to the delivery of the plan by electronic transmittal or electronic posting, to the delivery of all communications related to the plan by electronic means, and to the electronic delivery of any health insurance identification card required by Code Section 33-24-57.1.

(c) Before consenting on behalf of a covered person, a plan sponsor shall confirm that the covered person routinely uses electronic communications during the normal course of employment.

(c.1) Before providing delivery of a health benefit plan by electronic transmittal or electronic posting, the insurer for the plan shall:

(1) Provide the covered person an opportunity to opt out of the electronic transmittal or electronic posting of the plan; and

(2) Document that the remaining conditions under subparagraphs (a)(2)(B) through (a)(2)(E) of Code Section 33-24-14 are satisfied.

(d) Before providing delivery of communications related to the plan or a health insurance identification card by electronic means, the insurer for the health benefit plan shall:

(1) Provide the covered person an opportunity to opt out of delivery by electronic means; and

(2) Document that the remaining conditions under paragraphs (4) through (9) of subsection (d) of Code Section 33-24-14 are satisfied.

History.

Code 1981, § 33-24-14.1, enacted by Ga. L. 2022, p. 315, § 1/HB 1308; Ga. L. 2024, p. 116, § 4/HB 984, effective July 1, 2024.

Effective date.

This Code section became effective July 1, 2022. See Editor's notes for applicability.

Amendments.

The 2024 amendment, effective July 1, 2024, rewrote subsection (b), which read: "The plan sponsor of a health benefit plan may, on behalf of a party enrolled in the plan, provide the consent to the mailing of all communications related to the plan by electronic means otherwise required by paragraph (2) of subsection (d) of Code Section 33-24-14 and to the electronic delivery of any health insurance identification card required by Code Section 33-24-57.1"; in subsection (c), substituted "covered person" for "party" twice and substituted "shall" for "must"; added subsection (c.1); at the beginning of subsection (d), inserted "of communications related to the plan or a health insurance identification card" and substituted "shall" for "must" at the end; and substituted "covered person" for "party" in paragraph (d)(1). See Editor's notes for applicability.

Editor's notes.

Ga. L. 2022, p. 315, § 2/HB 1308, not codified by the General Assembly, makes this Code section applicable to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after July 1, 2022.

Ga. L. 2024, p. 116, § 6(b)/HB 984, not codified by the General Assembly, makes this Code section applicable to all policies, certificates, or contracts issued, delivered, issued for delivery, or renewed in this state on or after July 1, 2024.

33-24-16. Construction of policies.

RESEARCH REFERENCES

ALR.

Implication and Meaning of "Primary Residence" in Insurance Coverage Disputes, 87 A.L.R.7th 6.

33-24-18. Contents of insurance policies and annuity contracts generally.

RESEARCH REFERENCES

ALR.

Taxes and Fees as Components of "Actual Cash Value" (ACV) in Insurance Policies, 81 A.L.R.7th 1.

33-24-28. Termination of coverage of dependent child upon attainment of specified age.

(a) An individual hospital or medical expense insurance policy or hospital contract which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to be developmentally disabled or physically disabled, provided that proof of disability and dependency is furnished to the insurer or hospital by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer

or corporation but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(b) A group hospital or medical expense insurance policy or hospital contract which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of the child while the child is and continues to be developmentally disabled or physically disabled, provided that proof of disability and dependency is furnished to the insurer or hospital by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(c) This Code section shall apply equally to health insurance policies issued pursuant to Chapters 29 and 30 of this title, coverage by health maintenance organizations under Chapter 21 of this title, and health care plans under Chapter 20 of this title.

History.

Code 1933, § 56-2440, enacted by Ga. L. 1972, p. 1156, § 1; Ga. L. 1995, p. 1302, § 13; Ga. L. 2009, p. 453, §§ 3-2, 3-6/HB 228; Ga. L. 2017, p. 164, § 22/HB 127; Ga. L. 2019, p. 386, § 42/SB 133; Ga. L. 2024, p. 116, § 5/HB 984, effective April 22, 2024.

Amendments.

The 2024 amendment, effective April 22, 2024, substituted "developmentally disabled or physically disabled, provided that proof of disability" for "both incapable of self-sustaining employment by reason of developmental disability or physical disability as determined by the Department of Behavioral Health and Developmental Disabilities and chiefly dependent upon the policyholder or subscriber for support and maintenance, provided proof of incapacity" in subsection (a) and substituted "developmentally disabled or physically disabled, provided that proof of disability" for "both incapable of self-sustaining employment by reason of developmental disability or physical disability as determined by the Department of Behavioral Health and Developmental Disabilities and chiefly dependent upon the employee or member for support and maintenance, provided proof of incapacity" in subsection (b).

RESEARCH REFERENCES

ALR.

Implication and Meaning of "Primary Residence" in Insurance Coverage Disputes, 87 A.L.R.7th 6.

33-24-28.1. Coverage of treatment of mental health or substance use disorders.

(a) As used in this Code section, the term:

(1) "Accident and sickness insurance benefit plan, policy, or contract" means:

(A) An individual accident and sickness insurance policy or contract, as defined in Chapter 29 of this title; or

(B) Any similar individual accident and sickness benefit plan, policy, or contract.

(2) "Addictive disease" has the same meaning as in Code Section 37-1-1.

(3) "Mental health or substance use disorder" means a mental illness or addictive disease.

(4) "Mental illness" has the same meaning as in Code Section 37-1-1.

(b) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for the treatment of mental health or substance use disorders for children, adolescents, and adults, which coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if such insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(c) The optional endorsement required to be made available under subsection (b) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to the treatment of mental health or substance use disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(d) Nothing in this Code section shall be construed to prohibit an insurer, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(e) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for the treatment of mental disorders that differs

from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.

(f) In the event that an insurer under this Code section is also subject to Code Section 33-1-27 and the federal Mental Health Parity Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26, then such Code section and federal act shall take precedence to the extent of any conflicting requirements contained in this Code section.

History.

Code 1933, § 56-2447, enacted by Ga. L. 1981, p. 896, § 1; Ga. L. 1984, p. 777, § 1; Ga. L. 1989, p. 14, § 33; Ga. L. 1998, p. 736, § 1; Ga. L. 2019, p. 386, § 43/SB 133; Ga. L. 2022, p. 26, § 1-5/HB 1013.

Amendments.

The 2022 amendment, effective July 1, 2022, deleted former paragraph (a)(2), which read: "'Mental disorder' shall have the same meaning as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The International Classification of Diseases* (World Health Organization) as of January 1, 1981, or as the Commissioner may further define such term by rule and regulation." and added present paragraphs (a)(2) through (a)(4); in subsection (b), substituted "mental health or substance use disorders for children, adolescents, and adults" for "mental disorders" in the middle of the first sentence, and deleted the former last sentence, which read: "In no event shall such an insurer be required to cover inpatient treatment for more than a maximum of 30 days per policy year or outpatient treatment for more than a maximum of 48 visits per policy year under individual policies."; substituted "mental health or substance use disorders" for "mental disorders" in the middle of subsection (c); and added subsection (f).

Editor's notes.

Ga. L. 2022, p. 26, § 1-1/HB 1013, not codified by the General Assembly, provides that: "This part shall be known and may be cited as the 'Georgia Mental Health Parity Act.'"

Ga. L. 2022, p. 26, § 1-9/HB 1013, not codified by the General Assembly, provides that: "If necessary to implement any of the provisions of this part relating to the Medicaid program, the Department of Community Health shall submit a Medicaid state plan amendment or waiver request to the United States Department of Health and Human Services."

Ga. L. 2022, p. 26, § 1-10/HB 1013, not codified by the General Assembly, provides that: "Nothing in this part shall be construed to impair any contracts in effect on June 30, 2022."

Law reviews.

For article, "HB 1013: Georgia Mental Health Parity Act," see 39 Ga. St. U.L. Rev. 145 (2022).

33-24-29. Coverage for treatment of mental disorders under accident and sickness insurance benefit plans providing major medical benefits covering small groups; federal law.

(a) As used in this Code section, the term:

(1) "Accident and sickness insurance benefit plan, policy, or contract" means:

(A) A group or blanket accident and sickness insurance policy or contract, as defined in Chapter 30 of this title;

(B) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(C) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(D) Any similar group accident and sickness benefit plan, policy, or contract.

(2) "Addictive disease" has the same meaning as in Code Section 37-1-1.

(3) "Mental health or substance use disorder" means a mental illness or addictive disease.

(4) "Mental illness" has the same meaning as in Code Section 37-1-1.

(b) This Code section shall apply only to accident and sickness insurance benefit plans, policies, or contracts, certificates evidencing coverage under a policy of insurance, or any other evidence of insurance issued by an insurer, delivered, or issued for delivery in this state, except for policies issued to an employer in another state which provide coverage for employees in this state who are employed by such employer policyholder, providing major medical benefits covering small groups as defined in subsection (a) of Code Section 33-30-12.

(c) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for the treatment of mental health or substance use disorders for children, adolescents, and adults, which coverage shall be at least as extensive and provide at least the same degree of coverage and the same annual and lifetime dollar limits, but which may provide for different limits on the number of inpatient treatment days and outpatient treatment visits, as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(d)(1) The optional endorsement required to be made available under subsection (c) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages which apply to the treatment of mental health or substance use disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or

contract, except for any differing limits on inpatient treatment days and outpatient treatment visits as provided under subsection (c) of this Code section and as otherwise provided in paragraph (2) of this subsection.

(2) The optional endorsement required to be made available under subsection (c) of this Code section may contain deductibles or coinsurance provisions which apply to the treatment of mental health or substance use disorders, and such deductibles or coinsurance provisions need not apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract; provided, however, that if a separate deductible applies to the treatment of mental disorders, it shall not exceed the deductible for medical or surgical coverages. A separate out-of-pocket limit may be applied to the treatment of mental disorders, which limit, in the case of an indemnity type plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages and which, in the case of a health maintenance organization plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages or the amount of $2,000.00 in 1998 and as annually adjusted thereafter according to the Consumer Price Index for health care, whichever is greater.

(e)(1) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(2) Nothing in this Code section shall be construed to prohibit any person issuing an accident and sickness insurance benefit plan, policy, or contract from providing the coverage required to be made available under subsection (c) of this Code section through an indemnity plan with or without designating preferred providers of services or from arranging for or providing services instead of indemnifying against the cost of such services, without regard to whether such method of providing coverage for treatment of mental health or substance use disorders applies generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(f) The requirements of this Code section with respect to a group or blanket accident and sickness insurance benefit plan, policy, or contract

shall be satisfied if the coverage specified in subsections (c) and (d) of this Code section is made available to the master policyholder of such plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, nonprofit corporation, health care plan, health maintenance organization, or master policyholder to provide or make available such coverage to any insured under such group or blanket plan, policy, or contract.

(g) This Code section is neither enacted pursuant to nor intended to implement the provisions of any federal law.

(h) In the event that an insurer under this Code section is also subject to Code Section 33-1-27 and the federal Mental Health Parity Addiction Equity Act of 2008, 42 U.S.C. Section 300gg-26, then such Code section and federal act shall take precedence to the extent of any conflicting requirements contained in this Code section.

History.

Code 1981, § 33-24-29, enacted by Ga. L. 1998, p. 736, § 2; Ga. L. 2001, p. 4, § 33; Ga. L. 2017, p. 164, § 26/HB 127; Ga. L. 2019, p. 386, § 44/SB 133; Ga. L. 2022, p. 26, § 1-6/HB 1013.

Amendments.

The 2022 amendment, effective July 1, 2022, deleted former paragraph (a)(2), which read: "'Mental disorder' shall have the same meaning as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The International Classification of Diseases* (World Health Organization) as of January 1, 1981, or as the Commissioner may further define such term by rule and regulation." and added present paragraphs (a)(2) through (a)(4); substituted "mental health or substance use disorders for children, adolescents, and adults" for "mental disorders" in the middle of the first sentence of subsection (c); substituted "mental health or substance use disorders" for "mental disorders" near the middle of paragraphs (d)(1), (d)(2), and (e)(2); and added subsection (h).

Editor's notes.

Ga. L. 2022, p. 26, § 1-1/HB 1013, not codified by the General Assembly, provides that: "This part shall be known and may be cited as the 'Georgia Mental Health Parity Act.'"

Ga. L. 2022, p. 26, § 1-9/HB 1013, not codified by the General Assembly, provides that: "If necessary to implement any of the provisions of this part relating to the Medicaid program, the Department of Community Health shall submit a Medicaid state plan amendment or waiver request to the United States Department of Health and Human Services."

Ga. L. 2022, p. 26, § 1-10/HB 1013, not codified by the General Assembly, provides that: "Nothing in this part shall be construed to impair any contracts in effect on June 30, 2022."

Law reviews.

For article, "HB 1013: Georgia Mental Health Parity Act," see 39 Ga. St. U.L. Rev. 145 (2022).

33-24-29.1. Coverage for mental disorders under accident and sickness insurance benefit plans providing major medical benefits covering all groups except small groups.

(a) As used in this Code section, the term:

(1) "Accident and sickness insurance benefit plan, policy, or contract" means:

(A) A group or blanket accident and sickness insurance policy or contract, as defined in Chapter 30 of this title;

(B) A group contract of the type issued by a health care plan established under Chapter 20 of this title;

(C) A group contract of the type issued by a health maintenance organization established under Chapter 21 of this title; or

(D) Any similar group accident and sickness benefit plan, policy, or contract.

(2) "Addictive disease" has the same meaning as in Code Section 37-1-1.

(3) "Mental health or substance use disorder" means a mental illness or addictive disease.

(4) "Mental illness" has the same meaning as in Code Section 37-1-1.

(b) This Code section shall apply only to accident and sickness insurance benefit plans, policies, or contracts, certificates evidencing coverage under a policy of insurance, or any other evidence of insurance issued by an insurer, delivered, or issued for delivery in this state, except for policies issued to an employer in another state which provide coverage for employees in this state who are employed by such employer policyholder, providing major medical benefits covering all groups except small groups as defined in subsection (a) of Code Section 33-30-12.

(c) Every insurer authorized to issue accident and sickness insurance benefit plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for the treatment of mental health or substance use disorders for children, adolescents, and adults, which coverage shall be at least as extensive and provide at least the same degree of coverage and the same annual and lifetime dollar limits as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(d)(1) The optional endorsement required to be made available under subsection (c) of this Code section shall not contain any exclusions,

reductions, or other limitations as to coverages, including without limitation limits on the number of inpatient treatment days and outpatient treatment visits, which apply to the treatment of mental health or substance use disorders unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract, except as otherwise provided in paragraph (2) of this subsection.

(2) The optional endorsement required to be made available under subsection (c) of this Code section may contain deductibles or coinsurance provisions which apply to the treatment of mental health or substance use disorders.

(e)(1) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(2) Nothing in this Code section shall be construed to prohibit any person issuing an accident and sickness insurance benefit plan, policy, or contract from providing the coverage required to be made available under subsection (c) of this Code section through an indemnity plan with or without designating preferred providers of services or from arranging for or providing services instead of indemnifying against the cost of such services, without regard to whether such method of providing coverage for treatment of mental health or substance use disorders applies generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(f) The requirements of this Code section with respect to a group or blanket accident and sickness insurance benefit plan, policy, or contract shall be satisfied if the coverage specified in subsections (c) and (d) of this Code section is made available to the master policyholder of such plan, policy, or contract. Nothing in this Code section shall be construed to require the group insurer, nonprofit corporation, health care plan, health maintenance organization, or master policyholder to provide or make available such coverage to any insured under such group or blanket plan, policy, or contract.

History.
Code 1981, § 33-24-29.1, enacted by Ga. L. 1998, p. 736, § 3; Ga. L. 2001, p. 4, § 33; Ga. L. 2017, p. 164, § 27/HB 127;

Ga. L. 2019, p. 386, § 45/SB 133; Ga. L. 2022, p. 26, § 1-7/HB 1013.

Amendments.

The 2022 amendment, effective July 1, 2022, deleted former paragraph (a)(2), which read: "'Mental disorder' shall have the same meaning as defined by *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association) or *The International Classification of Diseases* (World Health Organization) as of January 1, 1981, or as the Commissioner may further define such term by rule and regulation." and added present paragraphs (a)(2) through (a)(4); substituted "mental health or substance use disorders for children, adolescents, and adults" for "mental disorders" in the middle of the first sentence in subsection (c); substituted "mental health or substance use disorders" for "mental disorders" near the middle of paragraphs (d)(1), (d)(2), and (e)(2); and deleted ", and such deductibles or coinsurance provisions need not apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract; provided, however, that if a separate deductible applies to the treatment of mental disorders, it shall not exceed the deductible for medical or surgical coverages. A separate out-of-pocket limit may be applied to the treatment of mental disorders, which limit, in the case of an indemnity type plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages and which, in the case of a health maintenance organization plan, shall not exceed the maximum out-of-pocket limit for medical or surgical coverages or the amount of $2,000.00 in 1998 and as annually adjusted thereafter according to the Consumer Price Index for health care, whichever is greater" from the end of paragraph (d)(2).

Editor's notes.

Ga. L. 2022, p. 26, § 1-1/HB 1013, not codified by the General Assembly, provides that: "This part shall be known and may be cited as the 'Georgia Mental Health Parity Act.'"

Ga. L. 2022, p. 26, § 1-9/HB 1013, not codified by the General Assembly, provides that: "If necessary to implement any of the provisions of this part relating to the Medicaid program, the Department of Community Health shall submit a Medicaid state plan amendment or waiver request to the United States Department of Health and Human Services."

Ga. L. 2022, p. 26, § 1-10/HB 1013, not codified by the General Assembly, provides that: "Nothing in this part shall be construed to impair any contracts in effect on June 30, 2022."

33-24-41. Discharge of insurer by payment generally.

JUDICIAL DECISIONS

Notice obligations. — Trial court did not err in granting summary judgment in favor of the life insurance company after the decedent's granddaughter claimed to be the rightful owner and beneficiary of the policy because the granddaughter did not provide notice to the insurance company of a competing claim prior to payment to the wife, and the insurance company, having no legal duty to investigate a fraudulent change of policy form, paid the person appearing on the face of the change of policy form. Emery v. Guarantee Trust Life Insurance Company, 358 Ga. App. 149, 854 S.E.2d 336, 2021 Ga. App. LEXIS 20 (2021).

33-24-41.1. Motor vehicle accident claim covered by two or more insurance carriers; limited release.

JUDICIAL DECISIONS

Effect of limited liability release. — In a case arising out of an auto accident resulting in the deaths of two women in different vehicles, the trial court properly

granted summary judgment to defendant as the limited liability release and plaintiffs' settlement with their uninsured motorist insurer released defendant from liability. Ferguson v. Spraggins, 371 Ga. App. 727, 902 S.E.2d 708, 2024 Ga. App. LEXIS 210 (2024).

Settlement for less than policy limit. Because the driver failed to exhaust the truck driver's employer's insurer's limits, the driver was precluded from making any recovery from his uninsured/underinsured motorist carrier. Farid v. Gaskell, 366 Ga. App. 7, 880 S.E.2d 576, 2022 Ga. App. LEXIS 517 (2022).

33-24-44. Cancellation of policies generally.

JUDICIAL DECISIONS

Analysis

General Consideration

General Consideration

Notice not required. — After the insurer denied the insureds' claim for the loss of their property in a fire, the trial court erred in failing to find that the insurance policy was not in effect at the time of the fire loss because any payments made to the insurance agent did not constitute payment to the insurer; and no notice from the insurer was required as the insurer did not cancel the initial policy; rather, once the initial policy expired by its own terms, the renewal policy never took effect due to the failure to pay premiums. Am. Reliable Ins. Co. v. Lancaster, 356 Ga. App. 854, 849 S.E.2d 697, 2020 Ga. App. LEXIS 541 (2020).

Applicability to termination by insured. — In a dispute regarding the proper construction of a refund provision in an automobile insurance policy, the trial court properly ruled that the provisions of O.C.G.A. § 33-24-44 were inapplicable to plaintiff's claim as that statutory provision explicitly applied to cancellations made by the insurer or its agent duly authorized by the insurer, and in the case at bar, plaintiff canceled the policy, not defendant. Mason v. Permanent General Assurance Corp., 370 Ga. App. 279, 896 S.E.2d 878, 2024 Ga. App. LEXIS 2 (2024).

In a dispute regarding the proper construction of a refund provision in an automobile insurance policy, the trial court properly ruled that the provisions of O.C.G.A. § 33-24-44 were inapplicable to plaintiff's claim as that statutory provision explicitly applied to cancellations made by the insurer or its agent duly authorized by the insurer, and in the case at bar, plaintiff canceled the policy, not defendant. Mason v. Permanent General Assurance Corp., 370 Ga. App. 279, 896 S.E.2d 878, 2024 Ga. App. LEXIS 2 (2024).

33-24-46. (Effective until January 1, 2026.) Cancellation or nonrenewal of certain property insurance policies.

(a) This Code section shall apply only to policies of insurance against direct loss to residential real property and the contents thereof, as defined and limited in standard fire policies insuring natural persons as the named insured.

(b) As used in this Code section, the term:

(1) "Claim against a policy" means a contact with an insurer by the insured under the policy or an affected third party for the express

purpose of seeking payment of proceeds under the terms of the policy in question. A report of loss or a question relating to coverage shall not independently establish a claim against a policy nor be considered as a claim under Article 2 of Chapter 6 of this title.

(2) "Nonrenewal" or "nonrenewed" means a refusal by an insurer or an affiliate of an insurer to renew. Failure of an insured to pay the premium as required of the insured for renewal, a change in policy terms, or a reduction in coverage after the insurer has manifested a willingness to renew by delivering a renewal policy, renewal certificate, or other evidence of renewal to the named insured or his or her representative or has offered to issue a renewal policy, certificate, or other evidence of renewal or has manifested such intention by any other means shall not be construed to be a nonrenewal.

(3) "Policies" means a policy insuring a natural person as named insured against direct loss to residential real property and the contents thereof, as defined and limited in standard fire policies as approved by the Commissioner.

(4) "Reduction in coverage" means a change made by the insurer which results in a removal of coverage, diminution in scope or less coverage, or the addition of an exclusion. Reduction in coverage shall not include any change, reduction, or elimination of coverage made at the request of the insured. The correction of typographical or scrivener's errors or the application of mandated legislative changes shall not be considered a reduction in coverage.

(5) "Renewal" means issuance and delivery by an insurer or an affiliate of such insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer or issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term or the extension of the term of a policy beyond its policy period or term pursuant to a provision for extending the policy by payment of a continuation premium. Any policy with a policy period or term of less than six months shall, for the purposes of this Code section, be considered to have successive policy periods ending each six months following its original date of issue and, regardless of its wording, any interim termination by its terms or by refusal to accept premiums shall be a cancellation subject to this Code section. Any policy written for a term longer than one year or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of one year and any termination by an insurer effective on an anniversary date of such policy shall be deemed a refusal to renew.

(c)(1) No notice of cancellation of a policy as to which this Code section applies shall be effective unless mailed or delivered as

prescribed in Code Section 33-24-44. The insurer shall provide the reason or reasons for such cancellation as required by Chapter 39 of this title.

(2) After coverage under a policy to which this Code section applies has been in effect more than 60 days or after the effective date of a renewal policy to which this Code section applies, a notice of cancellation may be issued only for one or more of the following reasons:

(A) Nonpayment of premium;

(B) Discovery of fraud, concealment of material fact, or material misrepresentation made by or with the knowledge of the insured in obtaining the policy, continuing the policy, or presenting a claim under the policy;

(C) The occurrence of a change in the risk which substantially increases any hazard the policy insures against; or

(D) The insured violates any of the material terms or conditions of the policy.

(d)(1) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the named insured. Such notice stating the time when nonrenewal will be effective, which shall not be less than 30 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured and of the lienholder, where applicable, and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service. The insurer shall provide the reason or reasons for nonrenewal as required by Chapter 39 of this title.

(2) An insurer shall provide a written notice of a reduction in coverage to the named insured no less than 30 days prior to the effective date of the proposed reduction in coverage; provided that such notice shall be in a separate document with the words "NOTICE OF REDUCTION IN COVERAGE" written in all capital letters in at least 12 point type. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(e) When a policy is canceled other than for nonpayment of premium or in the event of a refusal to renew or continue a policy, the insurer shall notify the named insured of his possible eligibility for insurance through the Georgia Fair Access to Insurance Requirements Plan. The notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew or not to continue the policy and shall state that such notice availability of the Georgia Fair Access to Insurance Requirements Plan is given pursuant to this Code section. Included in the notice shall be the address by which the Georgia Fair Access to Insurance Requirements Plan might be contacted in order to determine eligibility.

(f) There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his employees or against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal for any statement made by any of them and in written notice of cancellation or nonrenewal or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal or providing information pertaining thereto or for statements made or evidence submitted at any formal or informal hearing conducted in connection therewith.

(g) Return of unearned premium, if any, due to cancellations as to which this Code section applies shall be processed in accordance with Code Section 33-24-44.

(h) Notice to the insured shall not be required by this Code section when a policy is canceled by an insurance premium finance company under a power of attorney contained in an insurance premium finance agreement if notification of the existence of the premium finance agreement has been given to the insurer in accordance with the provisions of Chapter 22 of this title. However, the insurer shall comply with the provisions of subsection (d) of Code Section 33-22-13 pertaining to notice to a governmental agency, mortgagee, or other third party. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of such governmental agency, mortgagee, or other third party and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(i) Cancellation by the insured shall be accomplished as provided in Code Section 33-24-44.1.

(j) No notice refusing the renewal of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such notice of nonrenewal for the following reasons:

(1) Lack of, lack of potential for, or failure to agree to a writing of supporting insurance business;

(2) A change in the insurer's eligibility rules or underwriting rules, provided that this paragraph shall not apply to a change in such rules if the change applies uniformly within a specific class or territory and such change has been approved by the Commissioner under subsection (k) of this Code section; and

(3) Two or fewer claims against the policy within the preceding 36 month period if such claims are not attributable to the negligent or intentional acts of the insured or of persons residing at the insured premises.

(k) If the insurer demonstrates to the satisfaction of the Commissioner that renewal would violate the provisions of this title or would be hazardous to its policyholders or the public, paragraph (2) of subsection (j) shall not apply.

(l)(1) If the insurer complies with subsection (d) of this Code section, no claim or action may be maintained with respect to a policy which is not renewed unless the named insured files a written notice with the insurer before the time at which nonrenewal becomes effective. The notice shall specify the manner in which the failure to renew is alleged to be unlawful under this subsection. In any subsequent action asserting a violation of subsection (c), (j), or (k) of this Code section, no violation may be alleged other than the specific allegations contained in the notice filed by the named insured.

(2) In addition to other requirements, a notice of nonrenewal shall contain the provisions of paragraph (1) of this subsection in substantially the form which follows:

"NOTICE

Code Section 33-24-46 of the Official Code of Georgia Annotated provides that this insurer must, upon request, furnish you with the reasons for the failure to renew this policy. If you wish to assert that the nonrenewal is unlawful, you must file a written notice with this insurer before the time at which the nonrenewal becomes effective. The notice must specify the manner in which the failure to renew is alleged to be unlawful.

If you do not file the written notice, you may not later assert a claim or action against this insurer based upon an unlawful nonrenewal."

(m)(1) Notwithstanding subsection (j) of this Code section, the termination of an agency relationship shall be valid as a reason for a failure to renew a policy. In such case, if the named insured wishes to retain the policy with the particular insurer, the insured shall locate

another agent of the insurer and apply for the policy with another agent of the insurer before the time at which the nonrenewal becomes effective. Upon receipt of the application, the insurer shall treat the application as a renewal and not as an original writing. Nothing in this paragraph shall abridge or supersede contractual rights of the terminated agency or the insurer, provided that these contractual rights do not adversely affect the privilege of the named insured to apply for renewal through another agent of the insurer.

(2) A notice of nonrenewal based upon the termination of an agency relationship shall contain the provisions of paragraph (1) of this subsection, in substantially the form which follows:

"NOTICE

Your policy has not been renewed because your present agent no longer represents this insurer. You have the option of procuring coverage through your present agent or retaining this policy by applying through another agent of this insurer. Code Section 33-24-46 of the Official Code of Georgia Annotated provides that if you will locate another agent of the insurer and apply for this policy before the time at which the nonrenewal becomes effective, this insurer will treat the application as a renewal and not as an application for a new policy."

History.

Code 1933, § 56-2430.3, enacted by Ga. L. 1978, p. 2017, § 1; Ga. L. 1984, p. 1345, § 6; Ga. L. 1987, p. 1466, § 4; Ga. L. 1988, p. 677, §§ 3, 4; Ga. L. 1993, p. 483, § 6; Ga. L. 1995, p. 1011, § 5; Ga. L. 1996, p. 767, § 2; Ga. L. 2004, p. 754, § 2; Ga. L. 2014, p. 829, §§ 9, 10/HB 645; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2018, p. 210, § 2/HB 760; Ga. L. 2019, p. 474, § 6/SB 156; Ga. L. 2019, p. 1056, § 33/SB 52.

Delayed effective date.

Code Section 33-24-46 is set out twice in this Code. This version is effective until January 1, 2026. For version effective January 1, 2026, see the following version.

33-24-46. (Effective January 1, 2026.) Cancellation or nonrenewal of certain property insurance policies.

(a) This Code section shall apply only to policies of insurance against direct loss to residential real property and the contents thereof, as defined and limited in standard fire policies insuring natural persons as the named insured.

(b) As used in this Code section, the term:

(1) "Claim against a policy" means a contact with an insurer by the insured under the policy or an affected third party for the express purpose of seeking payment of proceeds under the terms of the policy in question. A report of loss or a question relating to coverage shall not independently establish a claim against a policy nor be considered as a claim under Article 2 of Chapter 6 of this title.

(2) "Nonrenewal" or "nonrenewed" means a refusal by an insurer or an affiliate of an insurer to renew. Failure of an insured to pay the premium as required of the insured for renewal, a change in policy terms, or a reduction in coverage after the insurer has manifested a willingness to renew by delivering a renewal policy, renewal certificate, or other evidence of renewal to the named insured or his or her representative or has offered to issue a renewal policy, certificate, or other evidence of renewal or has manifested such intention by any other means shall not be construed to be a nonrenewal.

(3) "Policies" means a policy insuring a natural person as named insured against direct loss to residential real property and the contents thereof, as defined and limited in standard fire policies as approved by the Commissioner.

(4) "Reduction in coverage" means a change made by the insurer which results in a removal of coverage, diminution in scope or less coverage, or the addition of an exclusion. Reduction in coverage shall not include any change, reduction, or elimination of coverage made at the request of the insured. The correction of typographical or scrivener's errors or the application of mandated legislative changes shall not be considered a reduction in coverage.

(5) "Renewal" means issuance and delivery by an insurer or an affiliate of such insurer of a policy superseding at the end of the policy period a policy previously issued and delivered by the same insurer or issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term or the extension of the term of a policy beyond its policy period or term pursuant to a provision for extending the policy by payment of a continuation premium. Any policy with a policy period or term of less than six months shall, for the purposes of this Code section, be considered to have successive policy periods ending each six months following its original date of issue and, regardless of its wording, any interim termination by its terms or by refusal to accept premiums shall be a cancellation subject to this Code section. Any policy written for a term longer than one year or any policy with no fixed expiration date shall be considered as if written for successive policy periods or terms of one year and any termination by an insurer effective on an anniversary date of such policy shall be deemed a refusal to renew.

(c)(1) No notice of cancellation of a policy as to which this Code section applies shall be effective unless mailed or delivered as prescribed in Code Section 33-24-44. The insurer shall provide the reason or reasons for such cancellation as required by Chapter 39 of this title.

(2) After coverage under a policy to which this Code section applies has been in effect more than 60 days or after the effective date of a

renewal policy to which this Code section applies, a notice of cancellation may be issued only for one or more of the following reasons:

(A) Nonpayment of premium;

(B) Discovery of fraud, concealment of material fact, or material misrepresentation made by or with the knowledge of the insured in obtaining the policy, continuing the policy, or presenting a claim under the policy;

(C) The occurrence of a change in the risk which substantially increases any hazard the policy insures against; or

(D) The insured violates any of the material terms or conditions of the policy.

(d)(1) No insurer shall refuse to renew a policy to which this Code section applies unless a written notice of nonrenewal is mailed or delivered in person to the named insured. Such notice stating the time when nonrenewal will be effective, which shall not be less than 60 days from the date of mailing or delivery of such notice of nonrenewal or such longer period as may be provided in the contract or by statute, shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured and of the lienholder, where applicable, and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service. The insurer shall provide the reason or reasons for nonrenewal as required by Chapter 39 of this title.

(2) An insurer shall provide a written notice of a reduction in coverage to the named insured no less than 30 days prior to the effective date of the proposed reduction in coverage; provided that such notice shall be in a separate document with the words "NOTICE OF REDUCTION IN COVERAGE" written in all capital letters in at least 12 point type. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of the insured and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(e) When a policy is canceled other than for nonpayment of premium or in the event of a refusal to renew or continue a policy, the insurer shall notify the named insured of his possible eligibility for insurance through the Georgia Fair Access to Insurance Requirements Plan. The

notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew or not to continue the policy and shall state that such notice availability of the Georgia Fair Access to Insurance Requirements Plan is given pursuant to this Code section. Included in the notice shall be the address by which the Georgia Fair Access to Insurance Requirements Plan might be contacted in order to determine eligibility.

(f) There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner or his employees or against any insurer, its authorized representatives, its agents, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal for any statement made by any of them and in written notice of cancellation or nonrenewal or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal or providing information pertaining thereto or for statements made or evidence submitted at any formal or informal hearing conducted in connection therewith.

(g) Return of unearned premium, if any, due to cancellations as to which this Code section applies shall be processed in accordance with Code Section 33-24-44.

(h) Notice to the insured shall not be required by this Code section when a policy is canceled by an insurance premium finance company under a power of attorney contained in an insurance premium finance agreement if notification of the existence of the premium finance agreement has been given to the insurer in accordance with the provisions of Chapter 22 of this title. However, the insurer shall comply with the provisions of subsection (d) of Code Section 33-22-13 pertaining to notice to a governmental agency, mortgagee, or other third party. Such notice shall be delivered as provided in subsection (d) of Code Section 33-24-14, in person, or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record of such governmental agency, mortgagee, or other third party and receiving the receipt provided by the United States Postal Service or such other evidence of mailing as prescribed or accepted by the United States Postal Service.

(i) Cancellation by the insured shall be accomplished as provided in Code Section 33-24-44.1.

(j) No notice refusing the renewal of a policy issued for delivery in this state shall be mailed or delivered by an insurer or its agent duly authorized to effect such notice of nonrenewal for the following reasons:

(1) Lack of, lack of potential for, or failure to agree to a writing of supporting insurance business;

(2) A change in the insurer's eligibility rules or underwriting rules,

provided that this paragraph shall not apply to a change in such rules if the change applies uniformly within a specific class or territory and such change has been approved by the Commissioner under subsection (k) of this Code section; and

(3) Two or fewer claims against the policy within the preceding 36 month period if such claims are not attributable to the negligent or intentional acts of the insured or of persons residing at the insured premises.

(k) If the insurer demonstrates to the satisfaction of the Commissioner that renewal would violate the provisions of this title or would be hazardous to its policyholders or the public, paragraph (2) of subsection (j) shall not apply.

(l)(1) If the insurer complies with subsection (d) of this Code section, no claim or action may be maintained with respect to a policy which is not renewed unless the named insured files a written notice with the insurer before the time at which nonrenewal becomes effective. The notice shall specify the manner in which the failure to renew is alleged to be unlawful under this subsection. In any subsequent action asserting a violation of subsection (c), (j), or (k) of this Code section, no violation may be alleged other than the specific allegations contained in the notice filed by the named insured.

(2) In addition to other requirements, a notice of nonrenewal shall contain the provisions of paragraph (1) of this subsection in substantially the form which follows:

"NOTICE

Code Section 33-24-46 of the Official Code of Georgia Annotated provides that this insurer must, upon request, furnish you with the reasons for the failure to renew this policy. If you wish to assert that the nonrenewal is unlawful, you must file a written notice with this insurer before the time at which the nonrenewal becomes effective. The notice must specify the manner in which the failure to renew is alleged to be unlawful.

If you do not file the written notice, you may not later assert a claim or action against this insurer based upon an unlawful nonrenewal."

(m)(1) Notwithstanding subsection (j) of this Code section, the termination of an agency relationship shall be valid as a reason for a failure to renew a policy. In such case, if the named insured wishes to retain the policy with the particular insurer, the insured shall locate another agent of the insurer and apply for the policy with another agent of the insurer before the time at which the nonrenewal becomes effective. Upon receipt of the application, the insurer shall treat the application as a renewal and not as an original writing. Nothing in

this paragraph shall abridge or supersede contractual rights of the terminated agency or the insurer, provided that these contractual rights do not adversely affect the privilege of the named insured to apply for renewal through another agent of the insurer.

(2) A notice of nonrenewal based upon the termination of an agency relationship shall contain the provisions of paragraph (1) of this subsection, in substantially the form which follows:

"NOTICE

Your policy has not been renewed because your present agent no longer represents this insurer. You have the option of procuring coverage through your present agent or retaining this policy by applying through another agent of this insurer. Code Section 33-24-46 of the Official Code of Georgia Annotated provides that if you will locate another agent of the insurer and apply for this policy before the time at which the nonrenewal becomes effective, this insurer will treat the application as a renewal and not as an application for a new policy."

History.

Code 1933, § 56-2430.3, enacted by Ga. L. 1978, p. 2017, § 1; Ga. L. 1984, p. 1345, § 6; Ga. L. 1987, p. 1466, § 4; Ga. L. 1988, p. 677, §§ 3, 4; Ga. L. 1993, p. 483, § 6; Ga. L. 1995, p. 1011, § 5; Ga. L. 1996, p. 767, § 2; Ga. L. 2004, p. 754, § 2; Ga. L. 2014, p. 829, §§ 9, 10/HB 645; Ga. L. 2015, p. 5, § 33/HB 90; Ga. L. 2018, p. 210, § 2/HB 760; Ga. L. 2019, p. 474, § 6/SB 156; Ga. L. 2019, p. 1056, § 33/SB 52; Ga. L. 2025, p. 690, § 1/SB 35, effective January 1, 2026.

Delayed effective date.

Code Section 33-24-46 is set out twice in this Code. This version is effective January 1, 2026. For version effective until January 1, 2026, see the preceding version.

Amendments.

The 2025 amendment, effective January 1, 2026, substituted "less than 60 days" for "less than 30 days" in the second sentence in paragraph (d)(1). See Editor's notes for applicability.

Editor's notes.

Ga. L. 2025, p. 690, § 2/SB 35, not codified by the General Assembly, provides, in part, that this act shall apply to all policies issued, delivered, issued for delivery, or renewed in this state on or after January 1, 2026.

33-24-51. Purchase of insurance covering injuries resulting from governmental ownership and use of motor vehicles; waiver of governmental immunity; limitation of liabilities.

Law reviews.

For article with annual survey on insurance law, see 73 Mercer L. Rev. 119 (2021).

For annual survey on insurance, see 74 Mercer L. Rev. 137 (2022).

JUDICIAL DECISIONS

Analysis

Waiver of Immunity
Applicability

Waiver of Immunity

Construction of subsection (b).

Use of a motor vehicle as provided in O.C.G.A. §§ 33-24-51(b) and 36-92-2 was not limited by the terms actively in use as a vehicle and loading a person into and restraining a person in a patrol car constituted a use of a patrol car as to which sovereign immunity was waived under O.C.G.A. §§ 33-24-51(b) and 36-92-2. McBrayer v. Scarbrough, 317 Ga. 387, 893 S.E.2d 660, 2023 Ga. LEXIS 221 (2023).

By reading into O.C.G.A. § 33-24-51(b) and O.C.G.A. § 36-92-2(a) the terms actively and as a vehicle, the Georgia Court of Appeals altered the plain meaning of "use" and restricted the scope of the local government's waiver of sovereign immunity; thus, the Georgia Supreme Court overruled that court's precedent construing use of a motor vehicle in O.C.G.A. § 33-24-51(b) and O.C.G.A. § 36-92-2(a) as being limited to the active use of the motor vehicle as a vehicle. McBrayer v. Scarbrough, 317 Ga. 387, 893 S.E.2d 660, 2023 Ga. LEXIS 221 (2023).

Waiver of sovereign immunity limited by terms of policy. — Court of appeals incorrectly ruled that the city's insurance policy increased the sovereign immunity waiver notwithstanding the immunity endorsements, which expressly precluded coverage when a sovereign immunity defense applied, as the insurance contract between the city and its insurer did not provide more than $700,000 of coverage for the plaintiffs' claims because, while the statutory defenses of sovereign and governmental immunity were clearly not applicable to losses from the plaintiffs' claims up to $700,000, pursuant to the endorsements, the insurance that the city purchased did not cover claims for damages to which the defenses of sovereign and governmental immunity did apply. Atlantic Specialty Ins. Co. v. City of College Park, 313 Ga. 294, 869 S.E.2d 492, 2022 Ga. LEXIS 22 (2022).

Plaintiff must allege waiver of governmental immunity.

Trial court did not err by granting the county and its sheriff summary judgment in the arrestee's lawsuit for false arrest and false imprisonment based on sovereign immunity because the allegations did not amount to the negligent use of a covered motor vehicle so as to give rise to a waiver of sovereign immunity under O.C.G.A. § 33-24-51. The arrestee alleged that the officer intentionally used a vehicle to detain and transport the arrestee as part of her alleged false arrest and imprisonment. Hooks v. Rockdale County, 373 Ga. App. 48, 907 S.E.2d 342, 2024 Ga. App. LEXIS 385 (2024).

Applicability

Negligence must arise from "use" of vehicle.

Where the plaintiff was injured after being struck by a car driven by a suspect fleeing from police, the plaintiff's losses did not arise out of any allegedly negligent use of an officer's police car because the officer's car was parked on the side of the road and was not used as part of the blockade to stop the fleeing suspect or divert the suspect onto the sidewalk where the plaintiff was located and, thus, the waiver of sovereign immunity was not applicable. City of Roswell v. Hernandez-Flores, 373 Ga. App. 436, 908 S.E.2d 694, 2024 Ga. App. LEXIS 453 (2024).

RESEARCH REFERENCES

ALR.

Supreme Court jurisprudence on governmental use of excessive force as violation of constitutional or civil rights, 80 A.L.R. Fed. 3d 3.

33-24-56.4. Short title; definitions; payment for telehealth services.

(a) This Code section shall be known and may be cited as the "Georgia Telehealth Act."

(b) As used in this Code section, the term:

(1) "Distant site" means a site at which a health care provider legally allowed to practice in this state is located while providing health care services by means of telemedicine or telehealth, which may include the home of the health care provider.

(2) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including, but not limited to, any health insurance plan established under Article 1 of Chapter 18 of Title 45 or under Article 7 of Chapter 4 of Title 49.

(3) "Insurer" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

(3.1) "Interprofessional consultation" means an assessment and management service in which a patient's health care provider seeks treatment advice from a consulting provider with specific specialty expertise to assist the patient's health care provider in diagnosing or treating the patient.

(4) "Originating site" means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, which may include a patient's home, workplace, or school; provided, however, that notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

(5) "Store and forward transfer" means the transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

(6) "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.

(7) "Telemedicine" means a form of telehealth which is the delivery of clinical health care services by means of real-time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient as prescribed by applicable federal and state laws, rules, and regulations, and legally allowed to practice in this state, while such patient is at an originating site and the health care provider is at a distant site. Such term includes audio-only telephone only when no other means of real-time two-way audio, visual, or other telecommunications or electronic communications are available to the patient due to lack of availability of such real-time two-way audio, visual, or other telecommunications or electronic communications, due to lack of adequate broadband access, or because the use of other means of real-time two-way audio, visual, or other telecommunications or electronic communications is infeasible, impractical, or otherwise not medically advisable, as determined by the health care provider providing telemedicine services to the patient or as determined by another health care provider with an existing relationship with the patient.

(c) It is the intent of the General Assembly to mitigate geographic discrimination in the delivery of health care by recognizing the application of and payment for covered medical care provided by means of telehealth, provided that such services are provided by a physician or by another health care practitioner or professional acting within the scope of practice of such health care practitioner or professional and in accordance with the provisions of Code Section 43-34-31.

(d) Each insurer proposing to issue a health benefit policy shall provide coverage for the cost of health care services provided through telehealth or telemedicine as directed through regulations promulgated by the department.

(e) An insurer shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(f) No insurer shall require an in-person consultation or contact

before a patient may receive telemedicine services from a health care provider, except for the purposes of initial installation, setup, or delivery of in-home telehealth devices or services, or as otherwise required by state or federal law, rule, or regulation.

(g) An insurer shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer is responsible for coverage for the provision of the same service through in-person consultation or contact; provided, however, that nothing in this subsection shall require (1) a health care provider or telemedicine company to accept more reimbursement than they are willing to charge or (2) an insurer to pay for a telemedicine service provided through an audio-only call for any service other than mental or behavioral health services. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health care services; provided, however, that this shall not require the insurer to include payment for transmission costs if the originating or distant site is a home.

(h) If a treating provider obtains interprofessional consultation from a consulting provider for a patient for whom the treating provider conducted an examination through telemedicine services, an insurer shall not require the consulting provider to conduct, either in-person or through telemedicine services, an examination of such patient in order to receive reimbursement, unless such examination by the consulting provider would be required for the provision of the same services when the initial examination of the patient by the treating provider was conducted through in-person consultation or contact.

(i) No insurer shall impose any deductible or annual or lifetime dollar maximum on coverage for telemedicine services other than a deductible or annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this Code section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the health benefit policy.

(j) No insurer shall require its insureds to use telemedicine services in lieu of in-person consultation or contact.

(k) On and after January 1, 2020, every health benefit policy that is issued, amended, or renewed shall include payment for services that are covered under such health benefit policy and are appropriately provided through telehealth in accordance with Code Section 43-34-31, this Code section, and generally accepted health care practices and

standards prevailing in the applicable professional community at the time the services were provided.

(l) No insurer shall impose any type of utilization review on telemedicine services unless such type of utilization review is imposed when the same services are provided through in-person consultation or contact.

(m) No insurer shall restrict coverage of telehealth or telemedicine services to services provided by a particular vendor, or other third party, or services provided through a particular electronic communications technology platform; provided, however, that nothing in this Code section shall require an insurer to cover any telehealth or telemedicine services provided through an electronic communications technology platform that does not comply with applicable state and federal privacy laws.

(n) No insurer shall place any restrictions on prescribing medications through telemedicine that are more restrictive than what is required under applicable state and federal laws for prescribing medications through in-person consultation or contact.

(o) A health care provider shall maintain documentation of each health care service provided through telemedicine in a manner that is at least as extensive and thorough as when the health care service is provided through in-person consultation or contact and, upon request, make such documentation available in accordance with applicable state and federal law.

(p) Nothing in this Code section shall be construed to limit, alter, or expand the scope of practice, standard of care, prescriptive authority, or supervision requirements for health care providers or privacy rights, other than as provided in applicable federal law and state laws, rules, and regulations.

History.

Code 1981, § 33-24-56.4, enacted by Ga. L. 2005, p. 481, § 3/HB 291; Ga. L. 2009, p. 859, § 11/HB 509; Ga. L. 2011, p. 752, § 33/HB 142; Ga. L. 2019, p. 386, § 56/SB 133; Ga. L. 2019, p. 512, § 1/SB 118; Ga. L. 2021, p. 378, § 1/HB 307.

Amendments.

The 2021 amendment, effective May 4, 2021, added ", which may include the home of the health care provider" at the end of paragraph (b)(1); added paragraph (b)(3.1); in paragraph (b)(4), deleted "in this state" following "means a site" at the beginning and substituted "which may include a patient's home, workplace, or school" for "unless the term is otherwise defined with respect to the provision in which it is used" in the middle; in paragraph (b)(7), substituted "real-time" for "real time" near the beginning of the first sentence, inserted "as prescribed by applicable federal and state laws, rules, and regulations" near the end of the first sentence, and added the last sentence; added subsections (f) and (h) and redesignated former subsections (f), (g), (h), and (i) as present subsections (g), (i), (j), and (k), respectively; in subsection (g), inserted "(1)" and "or (2) and insurer to pay for a telemedicine service provided through an audio-only call for any service other than mental or behavioral health services" at the end of the first sentence, and added

the proviso at the end of the second sentence; in subsection (i), inserted "deductible or" and substituted "than a deductible or annual" for "than an annual" near the beginning; and added subsections (l) through (p).

33-24-58.2. Newborn Baby and Mother Protection Act; minimum health benefit policy coverage; prohibited actions by insurance providers; required notice to mother.

Cross references.
Maternity supportive housing residences, § 49-5-25.

33-24-59.4. Confidentiality of medical information obtained from pharmacies; restrictions on release of information; penalty for violation.

Law reviews.
For article, "Privacy for Student-Patients: A Call to Action," see 73 Emory L.J. 83 (2023).

33-24-59.5. Definitions; timely payment of health benefits; notification of failure to pay; penalties; applicability.

JUDICIAL DECISIONS

Preemption. — Because self-funded plans would have different timeliness obligations in different states if amended state prompt-pay legislation went into effect, ERISA preempted the challenged provisions as relating to benefit plans, regardless of whether risk pooling was affected for saving clause purposes; ERISA's deemer clause applied. America's Health Ins. Plans v. Hudgens, 742 F.3d 1319, 2014 U.S. App. LEXIS 2771 (11th Cir. 2014).

33-24-59.15. (Effective until January 1, 2026.) Definitions; dental insurance.

(a) As used in this Code section:

(1) "Covered dental services" means dental care services for which a reimbursement is available under a covered person's dental benefit plan, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(2) "Covered person" means any subscriber, enrollee, member, beneficiary, or participant, or his or her dependent, for whom benefits are payable when that covered person receives dental care services rendered or authorized by a dentist licensed under Chapter 11 of Title 43.

(3) "Dental benefit plan" means any individual or group plan,

policy, contract, or subscription agreement which includes or is for dental care services that is issued, delivered, issued for delivery, or renewed in this state whether by a health care insurer, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, health care plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes dental care services to patients, insureds, beneficiaries, or covered dependents in this state.

(4) "Dental insurer" means any person, firm, corporation, joint venture, or other similar business entity that offers dental benefit plans in consideration of periodic payments.

(b) No contract between a dental insurer and a dentist shall require a dentist to accept an amount set by the dental insurer as payment for dental care services that are not covered dental services under the covered person's dental benefit plan.

(c) A dental insurer or other person or entity providing third-party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

(d) A dental insurer shall not draft, publish, disseminate, or circulate explanation of benefit forms that include language which directly or indirectly implies that a dentist may or should extend discounts to patients for noncovered dental services. Statements by a dental insurer which are prohibited by this Code section include but are not limited to, "Our members value the services you provide and we encourage you to continue extending the discount on noncovered services."

History.
Code 1981, § 33-24-59.15, enacted by Ga. L. 2011, p. 609, § 2/HB 189; Ga. L. 2017, p. 164, § 36/HB 127.
Delayed effective date.
Code Section 33-24-59.15 is set out twice in this Code. This version is effective until January 1, 2026. For version effective January 1, 2026, see the following version.

33-24-59.15. (Effective January 1, 2026.) Definitions; dental insurance; prohibited activities.

(a) As used in this Code section:

(1) "Care management organization" shall have the same meaning as set forth in Code Section 33-21A-2.

(2) "Covered dental services" means dental care services for which a reimbursement is available under a covered person's dental benefit plan, or for which a reimbursement would be available but for the

application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(3) "Covered person" means any subscriber, enrollee, member, beneficiary, or participant, or his or her dependent, for whom benefits are payable when that covered person receives dental care services rendered or authorized by a dentist licensed under Chapter 11 of Title 43.

(4) "Dental benefit plan" means any individual or group plan, policy, contract, or subscription agreement which includes or is for dental care services that is issued, delivered, issued for delivery, or renewed in this state whether by a healthcare insurer, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, healthcare plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes dental care services to patients, insureds, beneficiaries, or covered dependents in this state.

(5) "Dental insurer" means any person, firm, corporation, joint venture, or other similar business entity that offers dental benefit plans in consideration of periodic payments.

(b) No contract between a dental insurer and a dentist shall require a dentist to accept an amount set by the dental insurer as payment for dental care services that are not covered dental services under the covered person's dental benefit plan.

(c) A dental insurer or other person or entity providing third-party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

(d) A dental insurer shall not draft, publish, disseminate, or circulate explanation of benefit forms that include language which directly or indirectly implies that a dentist may or should extend discounts to patients for noncovered dental services. Statements by a dental insurer which are prohibited by this Code section include but are not limited to, Our members value the services you provide and we encourage you to continue extending the discount on noncovered services.

(e) Any dental benefit plan issued, amended, or renewed on or after January 1, 2026, between a dental insurer, contracted vendor thereof, or a care management organization and a healthcare provider for the provision of healthcare services to a plan enrollee may provide coverage for the cost of dental care provided through teledentistry as directed through regulations promulgated by the Commissioner.

(f) A dental insurer, contracted vendor thereof, or care management organization shall not:

(1) Exclude a service appropriately provided through teledentistry from coverage solely because the service is provided through teledentistry and is not provided through in-person consultation or contact between an authorizing dentist and a patient; or

(2) Require its insureds to receive dental care through teledentistry in lieu of an in-person, clinical examination.

History.

Code 1981, § 33-24-59.15, enacted by Ga. L. 2011, p. 609, § 2/HB 189; Ga. L. 2017, p. 164, § 36/HB 127; Ga. L. 2025, p. 260, § 2/HB 567, effective January 1, 2026.

Delayed effective date.

Code Section 33-24-59.15 is set out twice in this Code. This version is effective January 1, 2026. For version effective until January 1, 2026, see the preceding version.

Amendments.

The 2025 amendment, effective January 1, 2026, added paragraph (a)(1); redesignated former paragraphs (a)(1) through (a)(4) as present paragraphs (a)(2) through (a)(5), respectively; substituted "healthcare" for "health care" twice in paragraph (a)(4); and added subsections (e) and (f).

33-24-59.27. Right to shop for insurance coverage; disclosure of pricing information; notice.

(a) This Code section shall be known and may be cited as the "Georgia Right to Shop Act."

(b) As used in this Code section, the term:

(1) "Covered person" means an individual who is covered under a health benefit policy.

(2) "Emergency services" means those physical or mental health care services that are provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, regardless of the initial, interim, final, or other diagnoses that are given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(3) "Health benefit policy" or "policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed in this state, including,

but not limited to, those contracts executed by the state on behalf of state employees under Article 1 of Chapter 18 of Title 45, by an insurer.

(4) "Health care provider" or "provider" means any physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advanced practice nurse, registered optician, licensed professional counselor, physical therapist, marriage and family therapist, chiropractor, athletic trainer qualified pursuant to Code Section 43-5-8, occupational therapist, speech language pathologist, audiologist, dietitian, or physician assistant.

(5) "Health care service" means:

(A) Physical and occupational therapy services;

(B) Obstetrical and gynecological services;

(C) Radiology and imaging services;

(D) Laboratory services;

(E) Infusion therapy;

(F) Inpatient or outpatient surgical procedures;

(G) Outpatient nonsurgical diagnostic tests or procedures; and

(H) Any services designated by the Commissioner as shoppable by health care consumers.

(6) "Hierarchical Condition Category Methodology" means a coding system designed by the Centers for Medicare and Medicaid Services to estimate future health care costs for patients.

(7) "Insurer" means an accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, health care corporation, health maintenance organization, preferred provider organization, provider sponsored health care corporation, managed care entity, or any similar entity authorized to issue contracts under this title or to provide health benefit policies.

(c) Each insurer shall make available on its publicly accessible website an interactive mechanism whereby any member of the public may:

(1) For each health benefit policy offered, compare the payment amounts accepted by in-network providers from such insurer for the provision of a particular health care service within the previous year;

(2) For each health benefit policy offered, obtain an estimate of the average amount accepted by in-network providers from such insurer for the provision of a particular health care service within the previous year;

(3) For each health benefit policy offered, obtain an estimate of the out-of-pocket costs that such covered person would owe his or her provider following the provision of a particular health care service;

(4) Compare quality metrics applicable to in-network providers for major diagnostic categories with adjustments by risk and severity based upon the Hierarchical Condition Category Methodology or a nationally recognized health care quality reporting standard designated by the Commissioner. Metrics shall be based on reasonably universal and uniform data bases with sufficient claim volume. If applicable to the provider, quality metrics shall include, but not be limited to:

(A) Risk adjusted and absolute hospital readmission rates;

(B) Risk adjusted and absolute hospitalization rates;

(C) Admission volume;

(D) Utilization volume;

(E) Risk adjusted rates of adverse events; and

(F) Risk adjusted and absolute relative total cost of care.

The Commissioner shall promulgate rules and regulations which define the following terms: risk adjusted hospital readmission rates, absolute hospital readmission rates, risk adjusted hospitalization rates, absolute hospitalization rates, admission volume, utilization volume, risk adjusted rates of adverse events, risk adjusted total cost of care, and absolute relative total cost of care. Such terms shall be defined in accordance with federal law or regulation or as otherwise determined necessary by the Commissioner; and

(5) Access any all-payer health claims data base which may be maintained by the department.

(d) An insurer shall provide notification on its website that the actual amount that a covered person will be responsible to pay following the receipt of a particular health care service may vary due to unforseen costs that arise during the provision of such service.

(e) Each estimate of out-of-pocket costs provided pursuant to paragraph (3) of subsection (c) of this Code section shall provide the following:

(1) The out-of-pocket costs a covered person may owe if he or she has exceeded his or her deductible; and

(2) The out-of-pocket costs a covered person may owe if he or she has not exceeded his or her deductible.

(f) An insurer may contract with a third party to satisfy part or all of the requirements of this Code section.

(g) Nothing in this Code section shall prohibit an insurer from charging a covered person cost sharing beyond that included in the estimate provided pursuant to paragraph (3) of subsection (c) of this Code section if such additional cost sharing resulted from the unforseen provision of additional health care services and the cost-sharing requirements of such unforseen health care services were disclosed in such covered person's policy or certificate of insurance.

(h) The requirements of this Code section, with the exception of paragraph (4) of subsection (c) of this Code section, shall not apply to any health maintenance organization health benefits plan as defined in paragraph (4) of Code Section 33-21-1.

(i) This Code section shall become effective on January 1, 2022.

History.

Code 1981, § 33-24-59.27, enacted by Ga. L. 2020, p. 666, § 1/SB 303; Ga. L. 2021, p. 402, § 1A/HB 454; Ga. L. 2021, p. 922, § 33/HB 497; Ga. L. 2022, p. 598, § 7/HB 1324.

Amendments.

The first 2021 amendment, effective July 1, 2021, added subsection (i).

The second 2021 amendment, effective May 10, 2021, part of an Act to revise, modernize, and correct the Code, substituted "sponsored health care" for "sponsored heath care" in the middle of paragraph (b)(7).

The 2022 amendment, effective July 1, 2022, inserted "physical or mental" and "regardless of the initial, interim, final, or other diagnoses that are given," at the beginning of paragraph (b)(2).

Editor's notes.

Ga. L. 2022, p. 598, § 1/HB 1324, not codified by the General Assembly, provides: "The General Assembly finds that: (1) This state recognizes a 'prudent layperson' standard with regard to the need for emergency care;

"(2) Insurance companies operating in this state are required to adhere to that standard;

"(3) Patients in this state have had emergency medical claims denied due to insurers' failure to adhere to the prudent layperson standard as intended;

"(4) The federal court system has recognized that this standard is not intended to look to the diagnosis that a patient receives. Rather, the only relevant considerations are the patient's symptoms and whether a prudent layperson would think that emergency medical attention is necessary based on those symptoms;

"(5) This legislative body has intended and continues to intend that the prudent layperson standard be applied in the same manner;

"(6) In order to better protect Georgians seeking emergency care, legislation is needed not to change the meaning but to clarify the intended application of the prudent layperson standard in this state; and

"(7) Nothing in this Act is intended to be applicable to healthcare plans which are subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq."

33-24-59.30. Requirements for health insurance issuer for anatomical gifts or organ transplants; medically inappropriate organ transplants.

(a) As used in this Code section, the term:

(1) "Attending health care provider" means the attending physician and any other person administering health care services at the

time of reference who is licensed, certified, or otherwise authorized or permitted by law to administer health care services in the ordinary course of business or the practice of a profession, including any person employed by or acting for any such authorized person.

(2) "Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan.

(3) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Such term shall not include a plan providing coverage for only excepted benefits as specified in Section 2791(c) of the federal Public Health Service Act, 42 U.S.C.A. Section 300gg-91(c) and short-term policies that have a term of less than 12 months.

(4) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including through a health benefit plan as defined in this subsection, and shall include a sickness and accident insurance company, a health maintenance organization, a preferred provider organization, or any similar entity, or any other entity providing a plan of health insurance or health benefits.

(b) A health insurance issuer that provides coverage for anatomical gifts, organ transplants, or related treatment and services shall not:

(1) Deny coverage to a covered person solely on the basis of the individual's disability;

(2) Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of a health benefit plan, solely for the purpose of avoiding the requirements of this subsection;

(3) Penalize or otherwise reduce or limit the reimbursement of an attending health care provider, or provide monetary or nonmonetary incentives to such a provider, to induce such provider to provide care to a covered person in a manner inconsistent with this Code section; or

(4) Reduce or limit coverage benefits to a patient for the medical or other health care services related to organ transplantation performed pursuant to this Code section as determined in consultation with the attending health care provider and patient.

(c) In the case of a health benefit plan maintained pursuant to one or more collective bargaining agreements between employee representa-

tives and one or more employers, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement imposed pursuant to this Code section shall not be treated as a termination of the collective bargaining agreement.

(d) Nothing in this Code section shall be deemed to require a health insurance issuer to provide coverage for a medically inappropriate organ transplant.

History.

Code 1981, § 33-24-59.30, enacted by Ga. L. 2021, p. 546, § 1-4/HB 128.

Effective date.

This Code section became effective July 1, 2021.

Editor's notes.

Ga. L. 2021, p. 546, § 1-1/HB 128, not codified by the General Assembly, provides: "This part shall be known and may be cited as 'Gracie's Law.'"

Ga. L. 2021, p. 546, § 1-2/HB 128, not codified by the General Assembly, provides: "The General Assembly finds that:

"(1) A mental or physical disability does not diminish a person's right to health care;

"(2) The Americans with Disabilities Act of 1990, 42 U.S.C. Section 12101 et seq., prohibits discrimination against persons with disabilities, yet many individuals with disabilities still experience discrimination in accessing critical health care services;

"(3) In other states, individuals with physical or mental disabilities have been denied lifesaving organ transplants based on assumptions that their lives are less worthy, that they are incapable of complying with posttransplant medical requirements, or that they lack adequate support systems to ensure compliance with post-transplant medical requirements;

"(4) Although organ transplant centers shall consider medical and psychosocial criteria when determining if a patient is suitable to receive an organ transplant, transplant centers that participate in Medicare, Medicaid, or other federally funded programs are required to use patient selection criteria that result in a fair and nondiscriminatory distribution of organs; and

"(5) Georgia residents in need of organ transplants are entitled to assurances that they will not encounter discrimination on the basis of a disability."

33-24-59.31. When a value-added product or service is not an unfair trade practice or unlawful inducement.

(a) For purposes of this Code section, the term "customer" means a policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured, or applicant.

(b) The following shall not be construed as an unfair trade practice under subsection (b) of Code Section 33-6-4 or an unlawful inducement under subsection (c) of Code Section 33-9-36:

(1) An insurer or insurance producer, by or through employees, affiliates, or third-party representatives, may offer or provide a value-added product or service to a customer at no or reduced cost when such product or service is not specified in the policy of insurance when:

(A) The value-added product or service relates to the insurance coverage;

(B) The value-added product or service is offered in a manner that is not unfairly discriminatory, and the availability of the value-added product or service is based on documented objective criteria that is maintained by the insurer or insurance producer and produced upon request by the Commissioner;

(C) The cost to the insurer or insurance producer for offering or providing the value-added product or service is reasonable in comparison to the premiums or insurance coverage for the policy class; and

(D) The value-added product or service is primarily designed to:

(i) Provide loss mitigation or loss control;

(ii) Reduce claim costs or claim settlement costs;

(iii) Provide education about liability risks or risk of loss to persons or property;

(iv) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk;

(v) Enhance the health of a customer;

(vi) Enhance the financial wellness of a customer through items such as education or financial planning services;

(vii) Provide post-loss services;

(viii) Incentivize behavioral changes to improve the health or reduce the risk of death or disability of a customer; or

(ix) Assist in the administration of employee or retiree benefit insurance coverage; and

(2) When an insurer or insurance producer does not have sufficient evidence but has a good-faith belief that the value-added product or service meets the criteria in subparagraph (D) of paragraph (1) of this Code section, the insurer or insurance producer may offer or provide a value-added product or service in a manner that is not unfairly discriminatory as part of a pilot program for no more than one year. An insurer or insurance producer must notify the Commissioner prior to implementing the pilot program and may proceed with such program unless the Commissioner objects in writing within 21 days of notice.

History.

Code 1981, § 33-24-59.31, enacted by Ga. L. 2022, p. 289, § 1/HB 1059; Ga. L. 2023, p. 130, § 1/HB 294, effective May 1, 2023.

Effective date.

This Code section became effective July 1, 2022. See Editor's notes for applicability.

Amendments.

The 2023 amendment, effective May 1, 2023, added subsection (a); designated the formerly undesignated provisions of this Code section as subsection (b), and, in subsection (b), inserted "to a customer" in paragraph (b)(1), added divisions (b)(1)(D)(v) and (b)(1)(D)(vi), redesignated former divisions (b)(1)(D)(v) and (b)(1)(D)(vi) as divisions (b)(1)(D)(vii) and (b)(1)(D)(viii), respectively, deleted "or" at the end of division (b)(1)(D)(vii), rewrote present division (b)(1)(D)(viii), which formerly read: "(vi) Encourage behavioral changes to reduce the risk of death or disability of a customer or potential customer that is a policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured or applicant; and", added division (b)(1)(D)(ix), and, in paragraph (b)(2), substituted "no more than one year" for "no more than a year" at the end of the first sentence.

Code Commission notes.

Pursuant to Code Section 28-9-5, in 2022, Code Section 33-24-59.31, as enacted by Ga. L. 2022, p. 578, § 2-1/HB 733, was redesignated as Code Section 33-24-59.32.

Editor's notes.

Ga. L. 2022, p. 289, § 2/HB 1059, not codified by the General Assembly, makes this Code section applicable to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after July 1, 2022.

Ga. L. 2023, p. 130, § 1/HB 294, which amends this Code section, was missing the directory language.

33-24-59.32. Cost-sharing requirements for diagnostic and supplemental breast screening examinations.

(a) As used in this Code section, the term:

(1) "Breast magnetic resonance imaging" or "breast MRI" means a diagnostic and screening tool, including standard and abbreviated breast MRI, that uses radio waves and magnets to produce detailed images of structures within the breast.

(2) "Breast ultrasound" means a noninvasive diagnostic and screening tool that uses high-frequency sound waves and their echoes to produce detailed images of structures within the breast.

(3) "Cost-sharing requirement" means a deductible, coinsurance, or copayment and any maximum limitation on the application of such a deductible, coinsurance, copayment, or similar out-of-pocket expense.

(4) "Diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is:

(A) Used to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or

(B) Used to evaluate an abnormality detected by another means of examination.

(5) "Health benefit policy" means any individual or group plan, policy, or contract for health care services issued, delivered, issued for delivery, executed, or renewed by an insurer in this state.

(6) "Insurer" means any person, corporation, or other entity authorized to provide health benefit policies under this title.

(7) "Mammogram" means a diagnostic or screening mammography exam using a low-dose X-ray to produce an image of the breast.

(8) "Supplemental breast screening examination" means a medically necessary and clinically appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is:

(A) Used to screen for breast cancer when there is no abnormality seen or suspected in the breast; or

(B) Based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

(b) A health benefit policy that provides coverage for diagnostic examinations for breast cancer shall include provisions that 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.

(c) Nothing in this Code section shall be construed to preclude existing utilization review provided under Chapter 46 of this title.

(d) If under federal law application of subsection (b) of this Code section would result in Health Savings Account ineligibility under Section 223 of the Internal Revenue Code, such cost-sharing requirement shall apply only for Health Savings Account qualified High Deductible Health Plans with respect to the deductible of such plan after the enrollee has satisfied the minimum deductible under Section 223 of the Internal Revenue Code, except with respect to items or services that are preventive care pursuant to Section 223(c)(2)(C) of the Internal Revenue Code, in which case the requirements of subsection (b) of this Code section shall apply regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code has been satisfied.

(e) The Commissioner shall promulgate rules and regulations necessary to implement the provisions of this Code section in accordance with current guidelines established by professional medical organizations such as the National Comprehensive Cancer Network.

History.

Code 1981, § 33-24-59.32, enacted by Ga. L. 2022, p. 578, § 2-1/HB 733; Ga. L. 2023, p. 318, § 1/HB 315, effective May 2, 2023.

Effective date.

This Code section became effective May 6, 2022. See Editor's notes for applicability.

Amendments.

The 2023 amendment, effective May 2, 2023, deleted ", as defined by the guidelines established by the National Comprehensive Cancer Network as of January 1, 2022," following "clinically appropriate" at the beginning of paragraphs (a)(4) and (a)(8) and added subsection (e). See Editor's notes for applicability.

Code Commission notes.

Pursuant to Code Section 28-9-5, in 2022, Code Section 33-24-59.31, as enacted by Ga. L. 2022, p. 578, § 2-1/HB 733, was redesignated as Code Section 33-24-59.32.

Editor's notes.

Ga. L. 2022, p. 578, § 3-1(c)/HB 733, not codified by the General Assembly, makes this Code section applicable to all such policies and contracts issued, delivered, issued for delivery, or renewed on or after January 1, 2023.

Ga. L. 2023, p. 318, § 2/HB 315, not codified by the General Assembly, provides, in part, that this Act shall apply to all applicable insurance policies issued, delivered, issued for delivery, or renewed on or after January 1, 2024.

33-24-59.33. Required coverage for biomarker testing.

(a) As used in this Code section, the term:

(1) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. Such term includes, but is not limited to, gene mutations, protein expression, known gene-drug interactions for medications, and characteristics of genes.

(2) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Such term includes, but is not limited to, single-analyte tests, multiplex panel tests, whole genome sequencing, protein expression, whole exome, and whole transcriptome.

(3) "Consensus statements" means statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict-of-interest policy. Such statements are aimed at specific clinical circumstances and base the statements on the best available evidence for the purpose of optimizing the outcomes of clinical care.

(4) "Health benefit policy" means any individual or group plan, policy, or contract for healthcare services issued, delivered, issued for delivery, or renewed in this state which provides major medical benefits, including those contracts executed by the State of Georgia on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a health care corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fra-

ternal benefit society, hospital service corporation, medical service corporation, or other insurer or similar entity.

(5) "Nationally recognized clinical practice guidelines" means evidence based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict-of-interest policy. Such guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

(b) All health benefit policies renewed or issued on or after July 1, 2023, shall include coverage for biomarker testing as provided in this Code section.

(c) Biomarker testing shall be covered 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, including, but not limited to:

(1) A labeled indication for a test that has been approved or cleared by the United States Food and Drug Administration (FDA);

(2) An indicated test for an FDA approved drug;

(3) A national coverage determination made by the federal Centers for Medicare and Medicaid Services or a local coverage determination made by a medicare administrative contractor;

(4) Nationally recognized clinical practice guidelines and consensus statements; or

(5) Warnings and precautions on FDA approved drugs.

(d) Health benefit policies shall ensure biomarker testing coverage is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

(e) The insurer or similar entity subject to this Code section shall approve or deny a prior authorization request and notify the enrollee and the enrollee's healthcare provider within seven calendar days for nonurgent requests or within 72 hours for urgent requests. If the insurer or similar entity fails to respond in accordance with such time frames, such request shall be deemed approved.

(f) Enrollees, healthcare providers, and testing service providers shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy or an adverse utilization review determination under a health benefit policy, including, but not limited to, the rights of consumers under Article 2 of Chapter 20A of

Title 33, the "Patient's Right to Independent Review Act." Such process shall be made readily accessible on the insurer's or similar entity's website.

History.
Code 1981, § 33-24-59.33, enacted by Ga. L. 2023, p. 322, § 1/HB 85, effective July 1, 2023.

Effective date.
This Code section became effective July 1, 2023.

Cross references.
Biomarker testing for Medicaid recipients, § 49-4-159.2.

33-24-59.34. Required medical coverage for standard fertility preservation services.

(a) As used in this Code section, the term:

(1) "Health benefit policy" means any individual or group plan, policy, or contract for healthcare services issued, delivered, issued for delivery, or renewed in this state by an insurer that provides major medical benefits. Such term shall not include any plans, policies, or contracts executed by the state. Such term shall not include self-funded, employer sponsored health insurance plans subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, as codified and amended at 29 U.S.C. Section 1001, et seq.

(2) "Iatrogenic infertility" means an impairment of fertility caused directly or indirectly by a medically necessary treatment for cancer, sickle cell disease, or lupus.

(3) "Insurer" means any person, corporation, or other entity authorized to provide health benefit policies under this title, including a healthcare corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, or any similar entity.

(4) "Medically necessary treatment" means a medically necessary treatment for cancer, sickle cell disease, or lupus that has a potential side effect of iatrogenic infertility. Such treatment includes but is not limited to the surgical removal of the primary or secondary reproductive organs, chemotherapy, radiation therapy, and bone marrow transplantation.

(5) "Standard fertility preservation services" means procedures to preserve fertility that are consistent with established medical practices or professional guidelines. Such services include but are not limited to egg, sperm, embryo, and ovarian tissue cryopreservation.

(b) Every health benefit policy renewed or issued after January 1,

2026, shall include coverage for expenses for standard fertility preservation services when a medically necessary treatment may directly or indirectly cause iatrogenic infertility in any covered person. Such coverage shall include evaluation expenses, laboratory assessments, medications, and treatments associated with standard fertility preservation services, including storage of gametes for up to one year.

(c) The coverage provided for in subsection (b) of this Code section may:

(1) Exclude costs associated with storage of gametes for more than one year;

(2) Include age restrictions;

(3) Include a lifetime limit per procedure per eligible insured; and

(4) Be limited to nonexperimental procedures.

(d) The benefits in a health benefit policy as provided in subsection (b) of this Code section shall be subject to the same deductibles, coinsurance, and copayment provisions established for all covered benefits within such health benefit policy. Special deductibles, coinsurance, copayment, or other limitations that are not generally applicable to other hospital, medical, or surgical services covered by a health benefit policy shall not be imposed on coverage for standard fertility preservation services.

(e) The Commissioner shall promulgate rules and regulations necessary to implement the provisions of this Code section in accordance with current guidelines established by professional medical organizations such as the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

History.
Code 1981, § 33-24-59.34, enacted by Ga. L. 2025, p. 170, § 1/HB 94, effective May 1, 2025.
Effective date.
This Code section became effective May 1, 2025.
Editor's notes.
Pursuant to Code Section 28-9-5, in 2025, Code Section 33-24-59.34, as enacted by Ga. L. 2025, p. 548, § 1/SB 101, was redesignated as Code Section 33-24-59.35 and Code Section 33-24-59.34, as enacted by Ga. L. 2025, p. 773, § 2-1/SB 5, was redesignated as Code Section 33-24-59.36.

33-24-59.35. Required coverage orthotic devices and prosthetic devices; reporting; regulation.

(a) As used in this Code section, the term:

(1) "Cost-sharing requirement" shall have the same meaning as set forth in Code Section 33-24-59.32.

(2) "Covered person" means an individual covered under a health benefit policy.

(3) "Health benefit policy" means any individual or group plan, policy, or contract for healthcare services issued, delivered, issued for delivery, or renewed in this state by an insurer that provides major medical benefits. Such term shall not include any plans, policies, or contracts executed by the state on behalf of state employees under Article 1 of Chapter 18 of Title 45 and shall not apply to the provision of healthcare services pursuant to a contract entered into by an insurer and the Department of Community Health for recipients of Medicaid. Such term shall not include self-funded, employer sponsored health insurance plans subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, as codified and amended at 29 U.S.C. Section 1001, et seq.

(4) "Health insurer" means any person, corporation, or other entity authorized to provide health benefit policies under this title.

(5) "Medically necessary" shall have the same meaning as set forth in Code Section 33-46-4 and shall be in accordance with nationally recognized clinical practice guidelines.

(6) "Nationally recognized clinical practice guidelines" means evidence based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Such guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

(7) "Orthotic device" or "orthosis" means a custom fabricated or custom fitted device that is designed, fabricated, modified, or fitted to correct, support, or compensate for a neuromusculoskeletal disorder or acquired condition for the purpose of stabilizing, stretching, or immobilizing a body part, improving alignment, preventing deformities, protecting against injury, or assisting with motion or function, and is worn on the outside of the body to help with such structural or functional problems. Such term does not include fabric or elastic supports, corsets, arch supports, low-temperature plastic splints, trusses, elastic hoses, canes, crutches, soft cervical collars, dental appliances, or other similar devices that are carried in stock and sold as over-the-counter items by a drug store, department store, corset shop, or surgical supply facility.

(8) "Prosthetic device" or "prosthesis" means a custom designed, fabricated, fitted, modified, or fitted and modified device to replace an absent external body part for purposes of restoring physiological

function or cosmesis or both. Such term does not include artificial eyes or ears; dental appliances; cosmetic devices such as artificial breasts, eyelashes, or wigs; or other devices that do not have a significant impact on mobility or the musculoskeletal functions of the body.

(b) All health benefit policies renewed or issued on or after January 1, 2026, shall include coverage for orthotic devices and prosthetic devices that are medically necessary for:

(1) Activities of daily living;

(2) Essential job related activities;

(3) Personal hygiene related activities, including, but not limited to, showering, bathing, and toileting; or

(4) Physical activities, including, but not limited to, running, biking, swimming, and strength training, so as to maximize the covered person's whole body health and both upper and lower limb function.

(c) The coverage provided for in this Code section shall include no more than three orthotic devices or prosthetic devices per affected limb per covered person during any three-year period. Such coverage shall include:

(1) All materials and components for the use of the orthotic device or prosthetic device, including:

(A) The orthosis or prosthesis;

(B) Structural components such as the socket;

(C) Suspension mechanisms such as the pin, lock, suction, and elevated vacuum;

(D) Hip joint, knee joint, foot, alignable parts, and terminal device;

(E) Connective components such as pads, bands, and cushions; and

(F) Consumable items such as socks, sleeves, and liners;

(2) Formulation of the device's design, fabrication, measurements and fittings;

(3) Education and training on using and maintaining such device; and

(4) The repair of such device and its components.

(d)(1) The replacement of an orthotic device or prosthetic device and its materials and components when such device is less than three

years old shall be medically necessary if there is adequate documentation of a change in the physiological condition of the covered person, an irreparable change in the condition of the device or any of its components, or the condition of the device or a component of the device requires repairs and the cost of such repairs would be more than 60 percent of the cost of the device.

(2) A socket replacement shall be medically necessary if there is adequate documentation of a physiological need, including, but not limited to, a change in the residual limb,a functional need change, irreparable damage, or wear and tear due to excessive weight of a covered person or physical demands of an active covered person.

(e) A health insurer shall not be required to replace or repair an orthotic device or prosthetic device due to misuse, malicious damage, gross neglect, loss, or theft.

(f) The coverage provided for in this Code section:

(1) Shall be considered as habilitative or rehabilitative benefits for purposes of any state or federal requirements for coverage of essential health benefits;

(2) Shall be comparable to coverage for other medical and surgical benefits under the health benefit policy, including restorative internal devices;

(3) May be subject to the same cost-sharing requirements that apply to other medical devices and services covered by the health benefit policy; provided, however, that such requirements shall not be solely applicable to such coverage; and

(4) May be limited, or the cost-sharing requirements for such coverage may be altered for out-of-network providers; provided, however, that any limitations shall not be more restrictive than the restrictions and requirements applicable to the out-of-network coverage for the policy's medical or surgical coverage.

(g) Nothing in this Code section shall be construed to prohibit a health insurer from issuing or renewing a health benefit policy which provides benefits greater than the minimum benefits required under this Code section or from issuing or renewing a policy which provides benefits which are generally more favorable to the covered person than those required under this Code section.

(h) By July 1, 2032, the Commissioner shall submit a report to the House Committee on Insurance and the Senate Insurance and Labor Committee regarding the implementation of the coverage required under this Code section. All health insurers issuing or renewing health benefit policies subject to the provisions of this Code section shall

provide the department with all data requested by the department for inclusion in such report, including, but limited to, the total number of claims submitted, the total number of claims paid, and the total amount of claims paid for the coverage provided for by this Code section for policy years from 2026 to 2030.

(i) The Commissioner shall promulgate rules and regulations necessary to implement the provisions of this Code section.

History.
Code 1981, § 33-24-59.35, enacted by Ga. L. 2025, p. 548, § 1/SB 101, effective May 13, 2025.
Effective date.
This Code section became effective May 13, 2025.
Editor's notes.
Pursuant to Code Section 28-9-5, in 2025, Code Section 33-24-59.34, as enacted by Ga. L. 2025, p. 548, § 1/SB 101, was redesignated as Code Section 33-24-59.35 and Code Section 33-24-59.34, as enacted by Ga. L. 2025, p. 773, § 2-1/SB 5, was redesignated as Code Section 33-24-59.36.

33-24-59.36. Required coverage for healthcare services for PANDAS or PANS.

(a) As used in this Code section, the term:

(1) "Health benefit policy" means any individual or group plan, policy, or contract for healthcare services issued, delivered, issued for delivery, or renewed in this state which provides major medical benefits, including those contracts executed by the State of Georgia on behalf of state employees under Article 1 of Chapter 18 of Title 45, by a healthcare corporation, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, hospital service corporation, medical service corporation, or other insurer or similar entity. Such term shall not include any self-insured health benefit plan subject to the exclusive jurisdiction of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq.

(2) "Nationally recognized clinical practice guidelines" means evidence based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Such guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

(3) "Pediatric acute-onset neuropsychiatric syndrome" or "PANS" means a class of acute-onset obsessive compulsive or tic disorders or other behavioral changes presenting in children and adolescents that

are not otherwise explained by another known neurologic or medical disorder.

(4) "Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections" or "PANDAS" means a condition in which a streptococcal infection in a child or adolescent causes the abrupt onset of clinically significant obsessions, compulsions, tics, or other neuropsychiatric symptoms or behavioral changes, or a relapsing and remitting course of symptom severity.

(b) All health benefit policies issued or renewed on or after July 1, 2025, shall include coverage for healthcare services for PANDAS or PANS for an individual covered under such policy as provided in this Code section.

(c) Healthcare services for PANDAS or PANS for an individual covered under a health benefit policy shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a covered person's disorder when such services are supported by nationally recognized clinical practice guidelines.

(d) The benefits in a health benefit policy as provided for in this Code section shall be subject to the same deductibles, coinsurance, copayment provisions, and other limitations established for all covered benefits within such health benefit policy. Special deductibles, coinsurance, copayment, and other limitations that are not generally applicable to other healthcare services covered by a health benefit policy shall not be imposed on coverage for healthcare services for PANDAS or PANS.

(e) The Commissioner shall promulgate rules and regulations necessary to implement the provisions of this Code section.

History.

Code 1981, § 33-24-59.36, enacted by Ga. L. 2025, p. 773, § 2-1/SB 5, effective July 1, 2025.

Effective date.

This Code section became effective July 1, 2025. See Editor's notes for applicability.

Editor's notes.

Pursuant to Code Section 28-9-5, in 2025, Code Section 33-24-59.34, as enacted by Ga. L. 2025, p. 548, § 1/SB 101, was redesignated as Code Section 33-24-59.35 and Code Section 33-24-59.34, as enacted by Ga. L. 2025, p. 773, § 2-1/SB 5, was redesignated as Code Section 33-24-59.36.

Ga. L. 2025, p. 773, § 3-1/SB 5, not codified by the General Assembly, makes this Code section applicable to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after July 1, 2025.

CHAPTER 25

LIFE INSURANCE

Sec.
33-25-5. Inclusion of provisions excluding or restricting liability for death; service member protections.

33-25-5. Inclusion of provisions excluding or restricting liability for death; service member protections.

(a) No policy of life insurance, except as stated in subsection (c) of this Code section, shall be delivered or issued for delivery in this state if it contains a provision which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that the policy may contain provisions excluding or restricting coverage as specified therein in the event of death under any one or more of the following circumstances:

(1) Death as a result, directly or indirectly, of war, declared or undeclared, or of any act or hazard of such war;

(2) Death as the result of aviation or any air travel or flight;

(3) Death as a result of a specified hazardous occupation or occupations;

(4) Death while the insured is a resident outside the continental United States and Canada; or

(5) Death within two years from the date of issue of the policy as a result of suicide, while sane or insane.

(b) A policy which contains any exclusion or restriction pursuant to subsection (a) of this Code section shall also provide that in the event of death under circumstances to which any such exclusion or restriction is applicable, the insurer will pay an amount not less than a reserve determined according to the Commissioner's reserve valuation method upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits or, if the policy provides no such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy with adjustment for indebtedness or dividend credit.

(c) This Code section shall not apply to group life insurance, except as stated in subsection (d) of this Code section, reinsurance, annuities, or to any provision of a life insurance policy, or contract supplemental thereto, relating to disability benefits, or to additional benefits in the event of death by accident or accidental means.

(d) No policy of group life insurance shall be delivered or issued for

delivery in this state if it contains a provision which excludes or restricts liability for death occurring while the insured is a service member of the regular or reserve component of the armed forces of the United States and such death is not a result, directly or indirectly, of war, declared or undeclared, or any act or hazard of such war.

(e) Nothing contained in this Code section shall prohibit any provision which in the opinion of the Commissioner is more favorable to the policyholder than a provision permitted by this Code section.

History.
Code 1933, § 56-2507, enacted by Ga. L. 1960, p. 289, § 1; Ga. L. 1984, p. 22, § 33; Ga. L. 2025, p. 253, § 1/SB 109, effective June 1, 2025.

Amendments.
The 2025 amendment, effective June 1, 2025, inserted "the" preceding "event" in subsection (a); inserted ", except as stated in subsection (d) of this Code section" in subsection (c); added subsection (d); and redesignated former subsection (d) as subsection (e).

33-25-13. Receipt of benefits from insurance policy of deceased by person found guilty of committing murder or voluntary manslaughter.

RESEARCH REFERENCES

ALR.
Inheritance under slayer statute by person determined to have acted in self-defense, 80 A.L.R.7th 5.

CHAPTER 28

ANNUITY AND PURE ENDOWMENT CONTRACTS

Sec.
33-28-3. Standard nonforfeiture provisions for individual deferred annuities.

33-28-3. Standard nonforfeiture provisions for individual deferred annuities.

(a) This Code section shall be known and may be cited as the "Standard Nonforfeiture Law for Individual Deferred Annuities."

(b) This Code section shall not apply to any reinsurance, group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, premium deposit fund, variable annuity, immediate

annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity, nor to any contract which shall be delivered outside this state through an agent or other representative of the company issuing the contract.

(c) No contract of annuity, except as stated in subsection (b) of this Code section, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or corresponding provisions which in the opinion of the Commissioner are at least as favorable to the contract holder upon cessation of payment of considerations under the contract:

(1) That upon cessation of payment of considerations under a contract, the company shall grant a paid-up annuity benefit on a plan stipulated in such contract of such value as is specified in subsections (e) through (h) and (j) of this Code section;

(2) If a contract provides for a lump sum settlement at maturity or at any other time, that upon surrender of such contract at or prior to the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in subsections (e) through (h) and (j) of this Code section and that interest shall be payable on such amount in the same manner, at the same rate, and subject to the same conditions as provided by Code Section 33-25-10 for payment of interest on proceeds or payments under an individual policy of life insurance. Subject to the provisions of this paragraph, the company shall reserve the right to defer the payment of the cash surrender benefit for a period of six months after demand for the benefit with surrender of the contract. The provisions of this paragraph requiring the payment of interest shall not apply to variable contracts which provide for annuity benefits which may vary according to the investment experience of any separate account or accounts maintained by the company as to such contract;

(3) A statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract together with sufficient information to determine the amounts of the benefits;

(4) A statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which such contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts credited by the company to such contract, any indebtedness to the company on such contract, or any prior withdrawals from or partial surrenders of such contract; and

(5) Notwithstanding the requirements of this subsection, any deferred annuity contract may provide that if no considerations have been received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in such contract arising from considerations paid prior to such period would be less than $20.00 monthly, the company may at its option terminate such contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by the payment shall be relieved of any further obligation under such contract.

(d) The minimum values as specified in subsections (e) through (h) and (j) of this Code section of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined by the Commissioner by rule and regulation based upon interest rates set by the Commissioner to reflect current and prevailing economic and financial conditions; provided, however, that such interest rates shall not be less than 0.15 percent per annum nor more than 3 percent per annum.

(e) Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(f) For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of such contract, such present value being calculated on the basis of an interest rate not more than 1 percent higher than the interest rate specified in such contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on such contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to such contract. In no event shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

(g) For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfei-

ture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in such contract for accumulating the net considerations to determine the maturity value and increased by any existing additional amounts credited by the company to such contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, in no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(h) For the purpose of determining the benefits calculated under subsections (f) and (g) of this Code section, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election shall be permitted by the contract but shall not be deemed to be later than the anniversary of the contract next following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

(i) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

(j) Any paid-up annuity, cash surrender, or death benefits available at any time, other than on the contract anniversary under any contract with fixed, scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(k) For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding subsections (e) through (h) and (j) of this Code section, additional

benefits payable in the event of total and permanent disability as reversionary annuity or deferred reversionary annuity benefits or as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by this Code section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits.

History.

Code 1933, § 56-2602.1, enacted by Ga. L. 1979, p. 1407, § 3; Ga. L. 1982, p. 3, § 33; Ga. L. 1990, p. 8, § 33; Ga. L. 1999, p. 536, § 2; Ga. L. 2000, p. 1486, § 1; Ga. L. 2003, p. 577, § 1; Ga. L. 2004, p. 578, § 1; Ga. L. 2019, p. 386, § 84/SB 133; Ga. L. 2020, p. 493, § 33/SB 429; Ga. L. 2022, p. 284, § 1/HB 1021.

Amendments.

The 2022 amendment, effective July 1, 2022, substituted "0.15 percent" for "1 percent" in subsection (d). See Editor's notes for applicability.

Editor's notes.

Ga. L. 2022, p. 284, § 2/HB 1021, not codified by the General Assembly, makes subsection (d) of this Code section applicable to all applicable contracts issued, delivered, issued for delivery, or renewed in this state on or after July 1, 2022.

CHAPTER 29

INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

Sec.

33-29-3.2. Coverage for mammograms, Pap smears, and prostate-specific antigen tests; notice of coverage.

33-29-3.2. Coverage for mammograms, Pap smears, and prostate-specific antigen tests; notice of coverage.

(a) As used in this Code section, the term:

(1) "Female at risk" means a woman:

(A) Who has a personal history of breast cancer;

(B) Who has a personal history of biopsy proven benign breast disease;

(C) Whose grandmother, mother, sister, or daughter has had breast cancer; or

(D) Who has not given birth prior to age 30.

(2)(A) "Mammogram" means any low-dose radiologic screening

procedure for the early detection of breast cancer provided to a woman and which utilizes equipment approved by the Department of Community Health dedicated specifically for mammography and includes a physician's interpretation of the results of the procedure or interpretation by a radiologist experienced in mammograms in accordance with guidelines established by the American College of Radiology.

(B) Reimbursement for a mammogram authorized under this Code section shall be made only if the facility in which the mammogram was performed meets accreditation standards established by the American College of Radiology or equivalent standards established by this state.

(C) Policies subject to this Code section shall contain coverage for mammograms made with at least the following frequency:

(i) Once as a base-line mammogram for any female who is at least 35 but less than 40 years of age;

(ii) Once every two years for any female who is at least 40 but less than 50 years of age;

(iii) Once every year for any female who is at least 50 years of age; and

(iv) When ordered by a physician for a female at risk.

(3) "Pap smear" or "Papanicolaou smear" means an examination, in accordance with standards established by the American College of Pathologists, of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the order of a physician, which examination may be made once a year or more often if ordered by a physician.

(4) "Policy" means any benefit plan, contract, or policy except a disability income policy, specified disease policy, or hospital indemnity policy.

(5) "Prostate-specific antigen test" means a measurement, in accordance with standards established by the American College of Pathologists, of a substance produced by the epithelium to determine if there is any benign or malignant prostate tissue.

(b)(1) Every insurer authorized to issue an individual accident and sickness insurance policy in this state which includes coverage for any female shall include as part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed coverage for mammograms and Pap smears for the covered females which at least meets the minimum requirements of this Code section.

(2) Every insurer authorized to issue an individual accident and sickness insurance policy in this state which includes coverage for any male shall include as a part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed coverage for annual prostate-specific antigen tests for the covered males who are 45 years of age or older, or for covered males who are 40 years of age or older, if ordered by a physician.

(c) The coverage required under subsection (b) of this Code section may be subject to such exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions as may be approved by the Commissioner.

(d) Nothing in this Code section shall be construed to prohibit the issuance of individual accident and sickness insurance policies which provide benefits greater than those required by subsection (b) of this Code section or more favorable to the insured than those required by subsection (b) of this Code section.

(e) The provisions of this Code section shall apply to individual accident and sickness insurance policies issued by a fraternal benefit society, a health care plan, a health maintenance organization, or any similar entity.

(f) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of Chapter 30 of this title, relating to preferred provider arrangements.

(g)(1) Every insurer subject to paragraph (1) of subsection (b) of this Code section shall provide notification to each female insured upon such female attaining the age of 40 of her coverage for mammograms and continuing annually thereafter, for as long as mammogram screening is recommended for such female insured based on her individual health status, as determined by her physician.

(2) Every insurer subject to paragraph (2) of subsection (b) of this Code section shall provide notification to each male insured upon such male attaining the age of 40 and annually thereafter of coverage for annual prostate-specific antigen tests for the covered males who are 45 years of age or older, or for covered males who are 40 years of age or older, if ordered by a physician.

History.

Code 1981, § 33-29-3.2, enacted by Ga. L. 1990, p. 1057, § 1; Ga. L. 1992, p. 1975, § 1; Ga. L. 2009, p. 453, § 1-4/HB 228; Ga. L. 2017, p. 164, § 39/HB 127; Ga. L. 2019, p. 386, § 88/SB 133; Ga. L. 2022, p. 584, § 1/HB 937; Ga. L. 2024, p. 346, § 1/HB 384, effective July 1, 2024.

Amendments.

The 2022 amendment, effective July 1, 2022, added subsection (g).

The 2024 amendment, effective July 1, 2024, designated the existing provisions of subsection (g) as paragraph (g)(1) and added paragraph (g)(2).

CHAPTER 29A

INDIVIDUAL HEALTH INSURANCE COVERAGE

Article 3

Individual Accident and Sickness Insurance

Sec.
33-29A-32. Commissioner to authorize insurers to offer individual accident and sickness insurance policies in Georgia that have been approved for issuance in other states.

ARTICLE 3

INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE

33-29A-32. Commissioner to authorize insurers to offer individual accident and sickness insurance policies in Georgia that have been approved for issuance in other states.

The Commissioner shall approve for sale in Georgia any individual accident and sickness insurance policy that is currently approved for issuance in another state where the insurer or the insurer's affiliate or subsidiary is authorized to transact insurance so long as the insurer or the insurer's affiliate or subsidiary filing and issuing such policy in Georgia is also authorized to transact insurance in this state pursuant to Chapter 3 of this title and provided that any such policy meets the requirements set forth in this article. Additionally, any insurer authorized to transact insurance in this state can offer an individual accident and sickness insurance policy with benefits equivalent to those in any policy approved for sale in Georgia under this article, provided that any such offered policy meets the requirements set forth in this article.

History.

Code 1981, § 33-29A-32, enacted by Ga. L. 2011, p. 789, § 1/HB 47; Ga. L. 2021, p. 922, § 33/HB 497.

Amendments.

The 2021 amendment, effective May 10, 2021, part of an Act to revise, modernize, and correct the Code, substituted "filing and issuing" for "filing and issuance" in the middle of the first sentence of this Code section.

CHAPTER 30

GROUP OR BLANKET ACCIDENT AND SICKNESS INSURANCE

Article 1

General Provisions

Sec.
33-30-13.1. Furnishing claims experience to policyholders.
33-30-16. Requirement to offer reasonably priced comprehensive major medical health insurance policy.

Article 2

Preferred Provider Arrangements

Sec.
33-30-22. Definitions.

ARTICLE 1

GENERAL PROVISIONS

33-30-13.1. Furnishing claims experience to policyholders.

(a) As used in this Code section, the term "insurer" means an accident and sickness insurer, fraternal benefit society, health care corporation, provider sponsored health care corporation, health maintenance organization, or any similar entity.

(b)(1) All insurers shall furnish, regardless of the rating methodology used, claims experience to group policyholders within 30 days of any policyholder's request unless such information has been furnished to the group policyholder within the preceding six months. Such claims experience shall be furnished for all groups of 20 or more covered employees, members, or enrollees, not including dependents, and shall include, but shall not be limited to:

(A) Earned premiums separated by policy year for at least the last two policy years, if applicable;

(B) Total paid claims and total incurred claims, inclusive of any high amount or pooled claims, including both capitated and non-capitated expenses set forth in the same manner as premiums; and

(C) Any amounts in excess of the individual pooling or stop-loss point applicable to the group.

(2) Insurers that utilize provider contracting methods including financial devices such as global fee arrangements to cover all medical expenses or other methods used to calculate premiums may make application to the Commissioner for approval of the use of an alternative form of claims experience reporting. The insurer must still provide Georgia experience on a group-specific basis or on such other reasonable basis as the Commissioner may approve for such

insurer, in advance, based upon a submission of an explanation and supporting documentation. Any insurer that received approval for an alternative form of group claims experience reporting to policyholders shall be required to seek the Commissioner's advance approval of a proposed response letter to group policyholders who request experience reporting. Such letter should describe the insurer's reasons for seeking an alternative reporting process and describe the alternative form of reporting approved by the Commissioner.

(3) Insurers may charge a reasonable fee for providing this information to group policyholders. The schedule or amount of fees to be charged group policyholders for providing this information shall be filed by each insurer with the Commissioner.

(4) In providing claims experience to group policyholders under this Code section, insurers shall adhere to all state and federal laws regarding disclosure of protected health or personal information.

History.

Code 1981, § 33-30-13.1, enacted by Ga. L. 2002, p. 8, § 4; Ga. L. 2017, p. 164, § 48/HB 127; Ga. L. 2024, p. 75, § 1/HB 63, effective July 1, 2024.

Amendments.

The 2024 amendment, effective July 1, 2024, substituted "groups of 20" for "groups of 51" in the second sentence in paragraph (b)(1), and inserted "or other methods used to calculate premiums" near the middle of the first sentence in paragraph (b)(2). See Editor's note for applicability.

Editor's notes.

Ga. L. 2024, p. 75, § 2/HB 63, not codified by the General Assembly, makes this Code section applicable to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after July 1, 2024.

33-30-16. Requirement to offer reasonably priced comprehensive major medical health insurance policy.

(a) As used in this Code section, the term:

(1) "Operative date" means the date on which either of the following occurs:

(A) A federal law is enacted which expressly repeals 42 U.S.C. Section 300gg-3 or 42 U.S.C. Section 300gg-4 of the PPACA; or

(B) 42 U.S.C. Section 300gg-3 or 42 U.S.C. Section 300gg-4 of the PPACA is invalidated by the United States Supreme Court.

(2) "PPACA" means the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

(3) "Preexisting medical condition" means a condition that was present before the effective date of coverage under a policy, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the effective date of coverage. Such term

includes a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual or a review of medical records relating to the preenrollment period.

(b)(1) Not later than 30 days after the operative date, and notwithstanding any other law to the contrary, every insurer issuing, delivering, or issuing for delivery comprehensive individual major medical health insurance policies in this state shall make at least one reasonably priced comprehensive major medical health insurance policy available to residents in the insurer's approved service areas of this state, and such insurer may not exclude, limit, deny, or delay coverage under such policy due to one or more preexisting medical conditions.

(2) Such insurer may not limit or exclude benefits under such policy, including a denial of coverage applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if coverage is denied, before the date of the denial.

(c) The comprehensive major medical health insurance policy that the insurer is required to offer under this Code section shall be a policy that had been actively marketed in this state by the insurer as of the operative date and that was also actively marketed in this state during the year immediately preceding the operative date.

History.
Code 1981, § 33-30-16, enacted by Ga. L. 2021, p. 512, § 1/HB 509.

Effective date.
This Code section became effective July 1, 2021.

ARTICLE 2

PREFERRED PROVIDER ARRANGEMENTS

33-30-22. Definitions.

As used in this article, the term:

(1) "Emergency services" or "emergency care" means those physical or mental health care services that are provided for a condition, including but not limited to a mental health condition or substance use disorder, in which a person is exhibiting acute symptoms of sufficient severity, including, but not limited to, severe pain, regardless of the initial, interim, final, or other diagnoses that are given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

"Emergency services" or "emergency care" includes medical services rendered after such person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which such services are furnished, unless each of the conditions of subdivision (a)(3)(C)(ii)(II) of the federal Public Health Service Act, 42 U.S.C. Section 300gg-111 are met.

(2) "Health benefit plan" means the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available.

(3) "Health care insurer" means an insurer, a fraternal benefit society, a health care plan, or a health maintenance organization authorized to sell accident and sickness insurance policies, subscriber certificates, or other contracts of insurance by whatever name called under this title.

(4) "Health care provider" means any person duly licensed or legally authorized to provide health care services.

(5) "Health care services" means services rendered or products sold by a health care provider within the scope of the provider's license or legal authorization. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, chiropractic, psychological, and pharmaceutical services or products.

(6) "Preferred provider" means a health care provider or group of providers who have contracted to provide specified covered services.

(7) "Preferred provider arrangement" means a contract between or on behalf of the health care insurer and a preferred provider which complies with all the requirements of this article.

History.

Code 1981, § 33-30-22, enacted by Ga. L. 1988, p. 1483, § 1; Ga. L. 2005, p. 481, § 15/HB 291; Ga. L. 2017, p. 164, § 50/HB 127; Ga. L. 2022, p. 598, § 8/HB 1324; Ga. L. 2022, p. 750, § 3/SB 566.

Amendments.

The first 2022 amendment, effective July 1, 2022, inserted "physical or mental" and "regardless of the initial, interim, final, or other diagnoses that are given," at the beginning of paragraph (1).

The second 2022 amendment, effective July 1, 2022, in paragraph (1), substituted "condition, including but not limited to a mental health condition or substance use disorder, in which a person is exhibiting acute symptoms of sufficient" for "condition of recent onset and sufficient" at the beginning and added the last undesignated sentence. See Editor's notes for applicability.

Editor's notes.

Ga. L. 2022, p. 598, § 1/HB 1324, not codified by the General Assembly, provides: "The General Assembly finds that:

"(1) This state recognizes a 'prudent layperson' standard with regard to the need for emergency care;

"(2) Insurance companies operating in this state are required to adhere to that standard;

"(3) Patients in this state have had emergency medical claims denied due to insurers' failure to adhere to the prudent layperson standard as intended;

"(4) The federal court system has recognized that this standard is not intended to look to the diagnosis that a patient receives. Rather, the only relevant considerations are the patient's symptoms and whether a prudent layperson would think that emergency medical attention is necessary based on those symptoms;

"(5) This legislative body has intended and continues to intend that the prudent layperson standard be applied in the same manner;

"(6) In order to better protect Georgians seeking emergency care, legislation is needed not to change the meaning but to clarify the intended application of the prudent layperson standard in this state; and

"(7) Nothing in this Act is intended to be applicable to healthcare plans which are subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq."

Ga. L. 2022, p. 750, § 4/SB 566, not codified by the General Assembly, makes paragraph (1) applicable to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after July 1, 2022.

CHAPTER 32

PROPERTY INSURANCE

Article 2

New or Retrofitted Insurable Properties

Sec.
33-32-10. Applicability; definitions.
33-32-11. Premium discount or insurance rate reduction; qualifications; records; rates and rating plans.

ARTICLE 1

GENERAL PROVISIONS

Editor's notes.

Ga. L. 2024, p. 383, § 1/HB 279, effective July 1, 2024, designated Code Sections 33-32-1 through 33-32-6 as this article.

33-32-1. Standard fire policy.

RESEARCH REFERENCES

ALR.

Implied Coinsured Status in Subrogation Claims, 81 A.L.R.7th 5.

33-32-3. Privilege of rebuilding or reinstating property sustaining loss or damage.

RESEARCH REFERENCES

ALR.
Taxes and Fees as Components of "Actual Cash Value" (ACV) in Insurance Policies, 81 A.L.R.7th 1.

ARTICLE 2

NEW OR RETROFITTED INSURABLE PROPERTIES

Effective date.
This article became effective July 1, 2024.

33-32-10. Applicability; definitions.

(a) This article shall apply to all insurers offering or providing insurance coverage in this state on single-family residential property, commercial property, or modular homes, as provided for in Code Section 33-32-11.

(b) As used in this article, the term:

(1) "Insurable property" means a single-family residential property, commercial property, or modular home located in this state that satisfies the codes, standards, or techniques provided for in Code Section 33-32-11. Such term shall not include a manufactured home or mobile home located in this state, except where expressly provided for in subsection (c) of Code Section 33-32-11.

(2) "Insurer" means any property and casualty insurance company offering or providing insurance coverage on one or more types of insurable property.

History.
Code 1981, § 33-32-10, enacted by Ga. L. 2024, p. 383, § 2/HB 279, effective July 1, 2024.

33-32-11. Premium discount or insurance rate reduction; qualifications; records; rates and rating plans.

(a) Not later than March 1, 2025, insurers shall provide a premium discount or insurance rate reduction for new or retrofitted residential insurable property in an amount and manner as established in subsection (e) of this Code section and in accordance with Code Section 33-32-10. In addition, insurers may offer additional adjustments in deductible or other credit rate differentials or a combination thereof. Such adjustments shall be available under the terms specified in this Code section to any owner who builds or locates a new residential

insurable property or who retrofits an existing residential insurable property to resist loss due to tornado, hurricane, or other catastrophic windstorm events.

(b) Not later than March 1, 2025, insurers shall provide a premium discount or insurance rate reduction for new or retrofitted commercial insurable property in an amount and manner as established in subsection (e) of this Code section and in accordance with Code Section 33-32-10. In addition, insurers may offer additional adjustments in deductible or other credit rate differentials or a combination thereof. Such adjustments shall be available under the terms specified in this Code section to any owner who builds or locates a new commercial insurable property or who retrofits an existing commercial insurable property to resist loss due to tornado, hurricane, or other catastrophic windstorm events.

(c) To be considered for any adjustment provided for in subsection (a) or (b) of this Code section, an insurable property shall be certified as constructed in accordance with the applicable Fortified Programs standards adopted by the Insurance Institute for Business and Home Safety as of January 1, 2023, or any other mitigation program standards approved by the Commissioner. An insurable property shall be certified as conforming to the applicable Fortified Programs standards by an Insurance Institute for Business and Home Safety certified evaluator. Zone 3 HUD code manufactured homes installed to specifications and regulations promulgated by the Commissioner shall also be considered for approval.

(d) An owner of insurable property claiming any adjustment under this Code section shall maintain sufficient certification records and construction records, including, but not limited to, a valid certification from the Insurance Institute for Business and Home Safety for compliance with the applicable Fortified Programs standards or other such records as the Commissioner shall determine by rule.

(e) Insurers required to submit rates and rating plans to the Commissioner shall submit an actuarially justified rating plan for any person who builds, locates, or retrofits an insurable property to comply with the requirements of subsection (c) of this Code section. An insurer is not required to provide the same amount of adjustment for a building code insurable property as such insurer would to an insurable property compliant with the applicable Fortified Programs standards or other standards provided for by rule. An adjustment shall only apply to policies that provide wind coverage and may apply to that portion of the premium for wind coverage or to the total premium if the insurer does not separate out its premium for wind coverage in its rate filing. The adjustment shall apply exclusively to the premium designated for the new or retrofitted insurable property. In addition to the requirements of

this Code section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

History.
Code 1981, § 33-32-11, enacted by Ga. L. 2024, p. 383, § 2/HB 279, effective July 1, 2024.

CHAPTER 34

MOTOR VEHICLE ACCIDENT REPARATIONS

33-34-4. Owner required to provide coverage.

JUDICIAL DECISIONS

Tractor not required to have liability insurance. — Because the tractor was not used for anything other than agricultural purposes, and thus was not required to be registered under Georgia law, the tractor was not required to have liability insurance. Nationwide Agribusiness Ins. Co. v. The Onionman Comp., 369 Ga. App. 597, 894 S.E.2d 152, 2023 Ga. App. LEXIS 496 (2023).

Rental cars. — Trial court erred by denying the rental car owner's motion to dismiss the complaint because the alleged failure to provide spot insurance to the driver had no causal connection to any of the driver's injuries; thus, the driver was prevented from pursuing a negligence action against the rental car owner for the owner's failure to comply with O.C.G.A. § 40-9-102. PV Holding Co. v. Poe, 360 Ga. App. 381, 861 S.E.2d 265, 2021 Ga. App. LEXIS 363 (2021).

CHAPTER 34A

VEHICLE PROTECTION PRODUCT WARRANTIES

RESEARCH REFERENCES

ALR.
Integration or Merger Clause in Vehicle Purchase Agreement or Installment Contract as Affecting Enforceability of Separately Executed Arbitration Clause, 52 A.L.R.7th 3.

CHAPTER 36

GEORGIA INSURERS INSOLVENCY POOL

Sec.
33-36-3. Definitions.

33-36-3. Definitions.

As used in this chapter, the term:

(1) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(2) "Affiliate of the insolvent insurer" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(3) "Control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact and any person disputing his or her status as an affiliate of an insurer authorized to do business in Georgia or an insolvent insurer may file a disclaimer in accordance with subsection (i) of Code Section 33-13-4.

(4)(A) "Covered claim" means an unpaid claim which:

(i) Arises out of a property or casualty insurance policy issued by an insurer which becomes an insolvent insurer which was authorized to do an insurance business in this state either at the time the policy was issued or when the insured event occurred; and

(ii) Is within any of the classes of claims under subparagraph (B) of this paragraph.

(B) A claim shall not be paid unless it arises out of an insurable event under a property or casualty insurance policy and it is:

(i) An unearned premium claim of a policyholder who at the time of the insolvency was a resident of this state;

(ii) An unearned premium claim of a policyholder under a policy affording coverage for property permanently situated in this state;

(iii) The claim of a policyholder or insured who at the time of the insured event was a resident of this state;

(iv) The claim of a person having an insurable interest in or related to property which was permanently situated in this state; or

(v) A claim under a liability or workers' compensation insurance policy when either the insured or third-party claimant was a resident of this state at the time of the insured event.

(C) A covered claim shall not include any claim in an amount of less than $50.00; provided, however, that any claim of $50.00 or more shall be paid in full.

(D) A covered claim shall not include that portion of any first-party claim which is in excess of the applicable limits provided in the policy or $300,000.00, whichever is less.

(E) A covered claim shall not include that portion of any third-party claim, other than a workers' compensation claim, which is in excess of the applicable limits provided in the policy or $300,000.00, whichever is less.

(F) A covered claim shall not include any obligation to insurers, reinsurers, insurance pools, underwriting associations, health maintenance organizations, hospital plan corporations, or professional health service corporations as subrogation recoveries, reinsurance recoveries, contribution, indemnification, or otherwise. No such claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, or professional health service corporation may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent such claim exceeds the pool obligation limitations set forth in this Code section.

(G) A covered claim shall not include any first-party claim by an insured whose net worth exceeds $10 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer; provided, however, that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; or any third-party claim relating to a policy of an insured whose net worth exceeds $25 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer; provided, however, that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; and further provided that this exclusion shall not apply to third-party claims against the insured where the insured has applied for or consented to the appointment of a receiver, trustee, or liquidator for all or a substantial part of its

assets, filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law or, if an order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

(H) A covered claim shall not include any first-party claims by an insured which is an affiliate of the insolvent insurer.

(I) A covered claim shall not include any claim or judgment for punitive damages and attorney's fees associated therewith against any insolvent insurer, its insured, or the insurers insolvency pool.

(J) A covered claim shall not include any workers' compensation benefits payable under subsection (e) or (f) of Code Section 34-9-221 or paragraph (2), (3), or (4) of subsection (b) of Code Section 34-9-108 after the effective date of the court order of rehabilitation or liquidation.

(K) A covered claim shall include a claim for unearned premium only if such claim derives from the payment of a stated premium and shall not include those which derive from an unstated premium such as calculated from audit, dividend, deposit, or retrospect plans. Further, a covered claim shall not include:

(i) That portion of a claim for unearned premium which is in excess of $20,000.00; or

(ii) A claim for unearned premium resulting from a policy which was not in force on the date of the final order of liquidation.

(L) A covered claim shall not include any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent.

(M) A covered claim shall not include any fee or other amount sought by or on behalf of an attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the pool. However, in such a case, the pool shall not offset amounts from any recovery paid to a claimant in such an action which the claimant has agreed are to be paid to the attorney in a contingency fee arrangement.

(N) A covered claim shall not include any claims for interest.

(O) Notwithstanding any other provision of this chapter, an insurance policy issued by a member insurer and later allocated, transferred, or assumed by, or otherwise made the sole responsibility of another insurer, pursuant to any provision of law of this state providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity, shall be considered to have been issued by a member insurer which is an insolvent insurer for the purposes of this chapter in the event that the insurer to which the policy has been allocated, transferred, assumed by, or otherwise made the sole responsibility of is placed in liquidation.

(P) An insurance policy that was issued by a nonmember insurer and later allocated, transferred, assumed by, or otherwise made the sole responsibility of a member insurer under any provision of law of this state described in subparagraph (O) of this paragraph shall not be considered to have been issued by a member insurer for the purposes of this chapter.

(5) "Insolvent insurer" means an insurer which was licensed to issue property or casualty insurance policies in this state at any time subsequent to July 1, 1970, and against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile or of this state and which order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

(6) "Insolvency pool" or "pool" means the Georgia Insurers Insolvency Pool established pursuant to Code Section 33-36-2.

(7) "Insured" means any named insured, any additional insured, any vendor, any lessor, or any other party identified as an insured under the policy as long as insurable interests remain relevant.

(8) "Insurer" or "company" means any corporation or organization that has held or currently holds a license to engage in the writing of property or casualty insurance policies in this state, including the exchanging of reciprocal or interinsurance contracts among individuals, partnerships, and corporations, except farmer assessment mutual insurers, county assessment mutual insurers, and municipal assessment mutual insurers.

(9) "Net direct written premiums" means direct gross premiums written on property or casualty insurance policies, less return premiums on the policies and dividends paid or credited to policyholders on such direct business. Premiums written by any authorized insurer on policies issued to self-insurers, whether or not designated as reinsurance contracts, shall be deemed net direct written premiums.

(10) "Person" means any individual or legal entity, including governmental entities.

(11) "Property and casualty insurance policies" or "policy" means any contract, including endorsements to such contract and without regard to the nature or form of the contract or endorsement, which provides coverages as enumerated in Code Sections 33-7-3 and 33-7-6, except:

(A) Life insurance and annuities (being that class of insurance referred to in Code Section 33-7-4);

(B) Accident, health, and disability insurance except where written as part of an automobile insurance contract (being that class of insurance referred to in Code Section 33-7-2);

(C) Title insurance (being that class of insurance referred to in Code Section 33-7-8);

(D) Credit life insurance (being that class of insurance referred to in paragraph (2) of Code Section 33-31-1);

(E) Credit insurance, vendors' single interest insurance, or collateral protection insurance, or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

(F) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks;

(G) Fidelity or surety bonds or any other bonding obligations;

(H) Insurance of warranties or service contracts including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement, or service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits;

(I) Ocean marine insurance;

(J) Any transaction or combination of transactions between a person, including affiliates of such person, and an insurer, including affiliates of such insurer, which involves the transfer of investment or credit risk unaccompanied by the transfer of insurance risk; or

(K) Any insurance provided by or guaranteed by government.

History.
Ga. L. 1970, p. 700, § 3; Ga. L. 1973, p. 497, §§ 1, 3; Ga. L. 1985, p. 1485, §§ 2-4; Ga. L. 1988, p. 13, § 33; Ga. L. 1989, p. 74,

§§ 3, 4; Ga. L. 1996, p. 912, § 6; Ga. L. 2005, p. 563, § 12/HB 407; Ga. L. 2013, p. 141, § 33/HB 79; Ga. L. 2019, p. 386, § 127/SB 133; Ga. L. 2024, p. 770, § 1/HB 1049, effective May 6, 2024.

Amendments.

The 2024 amendment, effective May 6, 2024, added subparagraphs (4)(O) and (4)(P).

33-36-6. Plan to govern members; rules; requirements for plan; assignment of claims or judgments against insolvent insurers; claimants of assets of insolvent insurers; jurisdiction; venue.

JUDICIAL DECISIONS

Board of Workers' Compensation had subject matter jurisdiction. — Where the Insolvency Pool (IP) became responsible for the plaintiff's claim, but the plaintiff recovered money from the at-fault driver's insurer and the plaintiff's own automobile liability insurer, because the resolution of the IP's claims regarding a set-off amount and a refund from the plaintiff was at least ancillary — if not directly related — to the resolution of the plaintiff's pending claim for workers' compensation benefits, and because the plaintiff's claim would be affected by the resolution of the IP's claims, the State Board of Workers' Compensation had subject matter jurisdiction to resolve the IP's claims; thus, to the extent that the IP wished to litigate those issues, it had to do so before the Board. Palmer v. Georgia Insurers Insolvency Pool, 361 Ga. App. 803, 865 S.E.2d 623, 2021 Ga. App. LEXIS 552 (2021).

33-36-9. Coverage afforded by insolvent insurers to become obligation of pool; investigation and settlement of claims by pool.

JUDICIAL DECISIONS

Board of Workers' Compensation had subject matter jurisdiction. — Where the Insolvency Pool (IP) became responsible for the plaintiff's claim, but the plaintiff recovered money from the at-fault driver's insurer and the plaintiff's own automobile liability insurer, because the resolution of the IP's claims regarding a set-off amount and a refund from the plaintiff was at least ancillary — if not directly related — to the resolution of the plaintiff's pending claim for workers' compensation benefits, and because the plaintiff's claim would be affected by the resolution of the IP's claims, the State Board of Workers' Compensation had subject matter jurisdiction to resolve the IP's claims; thus, to the extent that the IP wished to litigate those issues, it had to do so before the Board. Palmer v. Georgia Insurers Insolvency Pool, 361 Ga. App. 803, 865 S.E.2d 623, 2021 Ga. App. LEXIS 552 (2021).

33-36-14. Exhaustion of rights by claimants against insolvent insurers prior to recovery; recovery of payment to claimants in excess of amounts authorized; reduction of liability of insured; recovery of amounts paid on behalf of certain persons.

JUDICIAL DECISIONS

Board of Workers' Compensation had subject matter jurisdiction. — Where the Insolvency Pool (IP) became responsible for the plaintiff's claim, but the plaintiff recovered money from the at-fault driver's insurer and the plaintiff's own automobile liability insurer, because the resolution of the IP's claims regarding a set-off amount and a refund from the plaintiff was at least ancillary — if not directly related — to the resolution of the plaintiff's pending claim for workers' compensation benefits, and because the plaintiff's claim would be affected by the resolution of the IP's claims, the State Board of Workers' Compensation had subject matter jurisdiction to resolve the IP's claims; thus, to the extent that the IP wished to litigate those issues, it had to do so before the Board. Palmer v. Georgia Insurers Insolvency Pool, 361 Ga. App. 803, 865 S.E.2d 623, 2021 Ga. App. LEXIS 552 (2021).

Reimbursement not permitted if no employment relationship at time of injury. — Georgia Insurers Insolvency Pool was not entitled to reimbursement from the solvent insurer of a business utilizing the services of a temporary staffing company when the staffing company's insurer became insolvent as the Pool Act only allowed reimbursement if the claim fell within the coverage of that insurer's policy and since the two workers did not have employment relationships with the businesses at the time of injury their claims did not fall within the policies issued. Ga. Insurers Insolvency Pool v. Carpet Cycle, LLC, 372 Ga. App. 408, 904 S.E.2d 506, 2024 Ga. App. LEXIS 310 (2024).

CHAPTER 37

INSURERS REHABILITATION AND LIQUIDATION

Article 3

Procedure for Rehabilitation

Sec.

33-37-31.1. Assumption of obligations by a guaranty association; reinsurance; mandatory negotiations between reinsurer and receiver; construction with other statutory provisions.

ARTICLE 3

PROCEDURE FOR REHABILITATION

33-37-31.1. Assumption of obligations by a guaranty association; reinsurance; mandatory negotiations between reinsurer and receiver; construction with other statutory provisions.

(a)(1) For purposes of this Code section, "guaranty association" means the Georgia Life and Health Insurance Guaranty Association

created by Chapter 38 of this title or any foreign guaranty association as defined in paragraph (10) of Code Section 33-37-3, unless context clearly requires a different construction.

(2) Contracts reinsuring life, disability income, health, or long-term care insurance policies or annuities issued by a ceding insurer that has been placed into liquidation pursuant to this chapter shall be continued, subject to the provisions of this Code section; provided, however, that, contracts terminated pursuant to contractual terms prior to the date of the order of liquidation or terminated pursuant to the order of liquidation shall be subject to the provisions of subsection (i) of this Code section.

(b)(1) At any time within 180 days of the date of the order of liquidation, a guaranty association covering life, disability income, health, or long-term care insurance policies or annuities, in whole or in part, may elect to assume the rights and obligations of the ceding insurer related to such policies under any one or more reinsurance contracts between the ceding insurer and its reinsurers. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be made by a guaranty association or the National Organization of Life and Health Insurance Guaranty Associations on its behalf by sending written notice, return receipt requested, to the affected reinsurers.

(2) To facilitate the decision, the receiver and each affected reinsurer shall make available upon request to any affected guaranty association or to the National Organization of Life and Health Insurance Guaranty Associations on their behalf copies of in-force reinsurance contracts and all related files and records relevant to the determination of whether such contracts should be assumed, and notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time may become a default under the reinsurance contracts.

(3) For reinsurance contracts assumed by a guaranty association, the following provisions shall apply:

(A) The guaranty association shall be responsible for all unpaid premiums due under the reinsurance contracts, for periods both before and after the date of the order of liquidation and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation;

(B) The guaranty association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods on or after the date of the order of liquidation;

(C) The guaranty association and the reinsurer shall, within 30 days following the date of such guaranty association's election to assume a reinsurance contract, calculate the balance due to or from such association under each reinsurance contract as of the date of such election, and such association or reinsurer shall pay any remaining balance due the other within 35 days of the date of such election. Any disputes over the amounts due to such association or reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contract, or, if the contract contains no arbitration clause, pursuant to the provisions of paragraph (3) of subsection (i) of this Code section; and

(D) If the guaranty association or receiver on behalf of such association, within 60 days of the date such association's election to assume a reinsurance contract, pays the unpaid premiums due for periods both before and after the date of such election that are due pursuant to the reinsurance contract, the reinsurer shall not be entitled to terminate the reinsurance contract for failure to pay premiums and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than such association, against amounts due the such association.

(c) When, pursuant to court approval provided for in Code Section 33-37-17, a receiver continues insurance policies or annuities following an order of liquidation, and the policies or annuities are not covered in whole or in part by one or more guaranty associations, the receiver may, within 180 days of the date of the order of liquidation, elect to assume the rights and obligations of the ceding insurer under any one or more of the reinsurance contracts that relate to the policies or annuities; provided, however, that the contracts have not been terminated as provided for in subsection (a) of this Code section. Such election shall be made by sending written notice, return receipt requested, to the affected reinsurers. After such notification to affected reinsurers has been made, payment of premiums on the reinsurance contracts for the policies and annuities, for periods both before and after the date of the order of liquidation, shall be chargeable against the estate as a Class 1 administrative expense. Amounts paid by the reinsurer on account of losses on the policies and annuities shall be to the estate of the ceding insurer.

(d) During the period from the date of the order of liquidation until the date a guaranty association or the receiver elects to assume the rights and obligations of the ceding insurer under any one or more of the reinsurance contracts that relate to the policies or annuities as provided for in subsection (b) or (c) of this Code section, the guaranty association, the receiver, and the reinsurer shall not have any rights or

obligations under any reinsurance contract that is eligible for assumption by such association or the receiver.

(e) When a guaranty association or the receiver timely elected to assume a reinsurance contract as provided for in subsection (b) or (c) of this Code section, the parties' rights and obligations shall be governed by subsection (b) or (c) of this Code section as applicable.

(f) When a guaranty association or the receiver does not timely elect to assume a reinsurance contract pursuant to subsection (b) or (c) of this Code section, the reinsurance contract shall be terminated retroactively effective on the date of the order of liquidation and subsection (i) of this Code section shall apply.

(g) When policies of life, disability income, health, or long-term care insurance or annuities, or the guaranty association's obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies or annuities may also be transferred by such association for contracts assumed as provided for in subsection (b) of this Code section, or by the receiver for contracts assumed as provided for in subsection (c) of this Code section; provided, however, that all of the following conditions are met:

(1) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies or annuities in addition to those transferred;

(2) The obligations described in subsections (b) and (c) of this Code section shall no longer apply with respect to matters arising after the effective date of the transfer; and

(3) Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days prior to the effective date of the transfer.

(h) The provisions of this Code section shall, to the extent provided in this Code section, supersede the provisions of law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the ceding insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to provisions of this chapter including applicable setoff provisions.

(i) When a reinsurance contract is terminated pursuant to this Code section, the reinsurer and the receiver shall commence a mandatory negotiation procedure in accordance with the following procedures:

(1) No later than 30 days after the date of termination, each party

shall appoint an actuary to determine an estimated sum due as a result of the termination of the reinsurance contract calculated in a way expected to make the parties economically indifferent as to whether the reinsurance contract continues or terminates, giving due regard to the economic effects of the insolvency. The sum shall take into account the present value of future cash flows expected under the reinsurance contract and be based on a gross premium valuation of net liability using current assumptions that reflect post-insolvency experience expectations, with no additional margins, net of any amounts payable and receivable, with a market value adjustment to reflect premature sale of assets to fund the settlement;

(2) Within 90 days of the date of termination, each party shall provide the other party with its estimate of the sum due as a result of the termination of the reinsurance contract, together with all relevant documents and other information supporting the estimate. The parties shall make a good faith effort to reach an agreement on the sum due;

(3) If the parties are unable to reach agreement within 90 days following the submission of materials as provided for in paragraph (2) of this subsection, either party may initiate arbitration proceedings as provided in the reinsurance contract. When the reinsurance contract does not contain an arbitration clause, either party may initiate arbitration pursuant to this paragraph by providing the other party with a written demand for arbitration. Such arbitration shall be conducted pursuant to the following procedures:

(A) Venue for the arbitration shall be within the county of the court's jurisdiction or another location agreed to by the parties;

(B) Within 30 days of the responding party's receipt of the arbitration demand, each party shall appoint an arbitrator who is a disinterested active or retired officer or executive of a life or health insurance or reinsurance company, or other professional with no less than ten years' experience in or relating to the field of life or health insurance or reinsurance. The two arbitrators shall appoint an independent, impartial, disinterested umpire who is an active or retired officer or executive of a life or health insurance or reinsurance company, or other professional with no less than ten years' experience in the field of life or health insurance or reinsurance. If the arbitrators are unable to agree on an umpire, each arbitrator shall provide the other with the names of three qualified individuals, each arbitrator shall strike two names from the other's list, and the umpire shall be chosen by drawing lots from the remaining individuals;

(C) Within 60 days following the appointment of the umpire, the parties shall submit to the arbitration panel, unless otherwise

order by the panel, their estimates of the sum due as a result of the termination of the reinsurance contract, together with all relevant documents and other information supporting the estimate;

(D) The time periods set forth in these subsections may be extended upon mutual agreement of the parties; and

(E) The panel shall have all powers necessary to conduct the arbitration proceedings in a fair and appropriate manner, including the power to request additional information from the parties, authorize discovery, hold hearings and hear testimony. The panel also may appoint independent actuarial experts, the expense of which shall be shared equally between the parties;

(4) An arbitration panel considering the matters set forth in this subsection shall apply the standards set forth in this subsection and shall issue a written award specifying a net settlement amount due from one party or the other as a result of the termination of the reinsurance contract. The receivership court shall confirm that award absent proof of statutory grounds for vacating or modifying arbitration awards under the Federal Arbitration Act, P.L. 68-401; and

(5) If the net settlement amount agreed or awarded as provided for in this subsection is payable by the reinsurer, the reinsurer shall pay the amount due to the estate, subject to any applicable setoff as provided for in Code Section 33-37-29. If the net settlement amount agreed or awarded pursuant to this subsection is payable by the ceding insurer, the reinsurer shall be deemed to have a timely filed claim against the estate for that amount, which claim shall be paid pursuant to the priority provided for in Code Section 33-37-41. The guaranty associations shall not be entitled to receive the net settlement amount, except to the extent they are entitled to share in the estate assets as creditors of the estate, and shall have no responsibility for the net settlement amount.

(j) Except as otherwise provided in this Code section, nothing in this Code section shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this Code section shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this Code section shall give a policyholder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this Code section shall limit or affect any guaranty association's rights as a creditor of the estate against the assets of the estate. Nothing in this Code section shall apply to reinsurance contracts covering property or casualty risks.

(k) This Code section and paragraph (20) of Code Section 33-38-7 shall be construed together in a manner that is consistent with each other and with the purpose provided for in Code Section 33-38-1.

History.
Code 1981, § 33-37-31.1, enacted by Ga. L. 2023, p. 130, § 2/HB 294, effective May 1, 2023.
Effective date.
This Code section became effective May 1, 2023.

Code Commission notes.
Pursuant to Code Section 28-9-5, in 2023, "from" was substituted for "for" in the last sentence of subparagraph (i)(3)(B).

CHAPTER 41

CAPTIVE INSURANCE COMPANIES

Article 1
General Provisions

Sec.
33-41-2. Definitions.
33-41-3. Permissible business; limitations.

ARTICLE 1
GENERAL PROVISIONS

33-41-2. Definitions.

Terms not defined in this chapter shall have the same meaning ascribed to them in this title. As used in this chapter, unless the context otherwise requires, the term:

(1) "Affiliate" means any person in the same corporate system as a parent, an industrial insured, or a member organization by virtue of common ownership, control, operation, or management.

(2) "Agency captive insurance company" means:

(A) Any domestic insurance company granted a certificate of authority pursuant to this chapter that is owned or controlled by an insurance agency, brokerage, managing general agent, or reinsurance intermediary, or an affiliate thereof, or under common ownership or control with such agency, brokerage, managing general agent, or reinsurance intermediary, and that only reinsures the risk of insurance or annuity contracts placed by or through such agency, brokerage, managing general agent, or reinsurance intermediary; or

(B) Any domestic insurance company granted a certificate of authority pursuant to this chapter that is owned or controlled by a

marketer, producer, administrator, issuer, or provider of service contracts or warranties and that only reinsures the contractual liability arising out of such service contracts or warranties sold through such marketer, producer, administrator, issuer, or provider.

(3) "Association" means any membership organization whose members consist of a group of individuals, corporations, partnerships, or other entities or associations who engage in similar or related professional, trade, or business activities and who collectively own, control, or hold with power to vote all of the outstanding voting interests of an association captive insurance company or of a person that is the sole shareholder of an association captive insurance company.

(4) "Association captive insurance company"' means any domestic insurance company granted a certificate of authority pursuant to this chapter to insure or reinsure the similar or related risks of members and affiliates of members of its association.

(5) "Captive insurance company" means any pure captive insurance company, association captive insurance company, agency captive insurance company, industrial insured captive insurance company, sponsored captive insurance company, or risk retention group captive insurance company.

(6) "Controlled unaffiliated business" means:

(A) Any person:

(i) That is not in the corporate system of a parent and its affiliated companies;

(ii) That has a reinsurance, risk-sharing, or other contractual relationship with a parent or one of its affiliated companies or is a direct or indirect investor in a pure captive insurance company; and

(iii) Whose risks are managed by or directly or indirectly ceded to a captive insurance company in accordance with this chapter and approved by the Commissioner; or

(B) A reinsurance arrangement with other captive insurance companies that is approved by the Commissioner.

(7) "Dormant captive insurance company" means a captive insurance company that:

(A) Has ceased transacting the business of insurance, including the issuance of insurance policies; and

(B) Has no remaining liabilities associated with insurance business transactions, or insurance policies issued prior to the filing of

its application for a certificate of dormancy pursuant to this chapter.

(8) "Formation documents" means articles of incorporation, if the captive insurance company or the prospective captive insurance company is a stock insurer, stock corporation, or a mutual insurer, or articles of organization, if the captive insurance company or the prospective captive insurance company is a limited liability company, and any amendments or restatements of the same. For purposes of this term, an incorporated protected cell, as defined in Article 2 of this chapter, shall be included in the definition of "captive insurance company."

(9) "Industrial insured" means an insured:

(A) Who procures the insurance of any risk or risks through the use of the services of a full-time employee who acts as an insurance manager, risk manager, or insurance buyer or through the services of a person licensed as a property and casualty agent, broker, or counselor in such person's state of domicile;

(B) Whose aggregate annual premiums for insurance on all risks total at least $25,000.00; and

(C) Who either:

(i) Has at least 25 full-time employees;

(ii) Has gross assets in excess of $3 million; or

(iii) Has annual gross revenues in excess of $5 million.

(10) "Industrial insured captive insurance company" means any domestic insurance company granted a certificate of authority pursuant to this chapter to insure or reinsure the risks of industrial insureds and their affiliates and which has as its shareholders or members only industrial insureds that are insured or reinsured by the industrial insured captive insurance company or which has as its sole shareholder or sole member an entity whose only owners are industrial insureds that are insured or reinsured by the industrial insured captive insurance company.

(11) "Mutual insurer" means an incorporated insurer without capital stock or shares that is owned and governed by its policyholders.

(12) "Parent" means an entity which directly or indirectly owns, controls, or holds with power to vote more than 50 percent of the total outstanding voting:

(A) Securities of a pure captive insurance company organized as a stock corporation; or

(B) Membership interests of a pure captive insurance company organized as a limited liability company.

(13) "Pure captive insurance company" means any domestic insurance company granted a certificate of authority under this chapter to insure or reinsure the risks of its parent and affiliates of its parent, and controlled unaffiliated business.

(14) "Risk retention group captive insurance company" is any domestic insurance company granted a certificate of authority pursuant to this chapter and determined by the Commissioner to be established and maintained as a "risk retention group" as defined under the federal Liability Risk Retention Act of 1986, as amended.

(15) "Stock insurer" means an incorporated insurer with capital divided into shares and owned by its shareholders.

(16) "Transact," as used in this chapter, shall not include the organizational activities associated with the preliminary formation, incorporation, petitioning for a certificate of authority, and initial capitalization of a captive insurance company.

History.

Code 1981, § 33-41-2, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 2015, p. 377, § 1-1/HB 552; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 1/SB 173; Ga. L. 2017, p. 774, § 33/HB 323; Ga. L. 2019, p. 533, § 2-2/HB 99; Ga. L. 2025, p. 633, § 2/HB 348, effective June 1, 2025.

Amendments.

The 2025 amendment, effective June 1, 2025, in division (6)(A)(ii), substituted "a reinsurance, risk-sharing, or other" for "an existing" near the beginning, and inserted "or is a direct or indirect investor in a pure captive insurance company" near the end; and inserted "or directly or indirectly ceded to" in division (6)(A)(iii).

33-41-3. Permissible business; limitations.

(a) Subject to the provisions of subsection (c) of this Code section and the other provisions of this chapter, a captive insurance company, where permitted by its formation documents, may engage in the business of any insurance or reinsurance that the Commissioner may deem reasonable.

(b) Insurance policies and bonds issued by a captive insurance company for workers' compensation insurance and motor vehicle accident insurance shall be in conformity with all minimum requirements for coverages and coverage amounts established by this state for such types of insurance. Such insurance policies and bonds issued by a captive insurance company shall constitute satisfactory proof that the motor vehicle owners or employers, as applicable, insured under such policies or bonds have satisfied the requirements for motor vehicle

accident insurance prescribed by Code Section 33-34-4 and for workers' compensation insurance prescribed by Code Section 34-9-121.

(c) Except as otherwise provided in this Code section:

(1) A captive insurance company shall not insure any risks resulting from:

(A) Any personal, familial, or household responsibilities; or

(B) Activities other than risks resulting from responsibilities arising out of any business, whether profit or nonprofit; trade; product; services, including professional or fiduciary services; or commercial premises or commercial operations;

(2) A captive insurance company may only cede reinsurance as provided in Code Section 33-41-14;

(3) A pure captive insurance company may only insure or reinsure the risks of its parent, affiliates of its parent, and controlled unaffiliated business;

(4) An association captive insurance company may only insure or reinsure the risks of the members of its association and their affiliates;

(5) An industrial insured captive insurance company may only insure or reinsure the risks of the industrial insureds, and their affiliates, that are its shareholders or shareholders of its sole shareholder;

(6) A risk retention group captive insurance company may only insure or reinsure the risks of its group members; and

(7) An agency captive insurance company may only reinsure:

(A) The risk of insurance or annuity contracts placed by or through the agency, brokerage, managing general agent, or reinsurance intermediary by which it is owned or controlled; or

(B) The contractual liability arising out of service contracts or warranties sold through a marketer, producer, administrator, issuer, or provider of service contracts or warranties by which it is owned or controlled.

(d) A captive insurance company may, with prior written approval from the Commissioner, reinsure the risks insured or reinsured either directly or indirectly by:

(1) Any other captive insurance company; or

(2) Any foreign or alien insurance company which satisfies the ownership or membership requirements of a captive insurance com-

pany under this chapter; provided, however, that the risks insured or reinsured from the foreign or alien insurance company are solely those of its owners or members or their affiliates.

History.

Code 1981, § 33-41-3, enacted by Ga. L. 1988, p. 966, § 2; Ga. L. 1989, p. 14, § 33; Ga. L. 2016, p. 825, § 1/SB 347; Ga. L. 2017, p. 682, § 2/SB 173; Ga. L. 2019, p. 533, § 2-3/HB 99; Ga. L. 2025, p. 633, § 3/HB 348, effective June 1, 2025.

Amendments.

The 2025 amendment, effective June 1, 2025, in subsection (a), substituted "of any insurance or reinsurance that the Commissioner may deem reasonable." for "of any of the following kinds of insurance or reinsurance:", and deleted former paragraphs (a)(1) through (a)(4).

CHAPTER 46

CERTIFICATION OF PRIVATE REVIEW AGENTS

Article 1

General Provisions

Sec.

33-46-1. Construction.

33-46-2. Application.

33-46-3. Legislative purposes and intent.

33-46-4. Definitions.

33-46-5. Certification of private review agents; exemption.

33-46-6. (Effective until January 1, 2026.) Requirements for certification; utilization of nationally recognized accreditation standards; website identifying nationally recognized accreditation entities.

33-46-6. (Effective January 1, 2026.) Requirements for certification; utilization of nationally recognized accreditation standards; website identifying nationally recognized accreditation entities.

33-46-7. Certificate application fees; information to be submitted with application.

33-46-8. Expiration and renewal of certificate.

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Article 2

Prior Authorizations

33-46-20. Prior authorization requirements posted on website; statistical reporting.

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tions when service timely rendered.
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ARTICLE 1

GENERAL PROVISIONS

Editor's notes.

Code Sections 33-46-1 through 33-46-16 were designated as Article 1 by Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022.

Ga. L. 2021, p. 629, § 1/SB 80, not codified by the General Assembly, provides: "This Act shall be known and may be cited as the 'Ensuring Transparency in Prior Authorization Act.'"

Ga. L. 2021, p. 629, § 3/SB 80, not codified by the General Assembly, provides: "This Act shall become effective on January 1, 2022, and shall apply to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after such date."

33-46-1. Construction.

This chapter shall be construed liberally to promote consumer protection.

History.

Code 1981, § 33-46-1, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

Editor's notes.

Ga. L. 2021, p. 629, § 1/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-1, relating to legislative purposes and intent, as present Code Section 33-46-3.

33-46-2. Application.

(a) This chapter applies to:

(1) Private review agents;

(2) Utilization review entities;

(3) All health insurers and stand-alone dental plans that provide accident and sickness insurance products whether on an individual, group, or blanket basis as provided in this title;

(4) All administrators of such products licensed in accordance with Article 2 of Chapter 23 of this title;

(5) All pharmacy benefits managers;

(6) All contracts entered into or renewed by the Department of Community Health with a contracted entity to provide healthcare coverage or services pursuant to the state health benefit plan; and

(7) All contracts entered into or renewed by the Department of Community Health and care management organizations to provide or arrange for healthcare coverage or services on a prepaid, capitated basis to members.

History.
Code 1981, § 33-46-2, enacted by Ga. L. 2021, p. 629, § 2/SB 80.
Editor's notes.
Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-2, relating to definitions, as present Code Section 33-46-4.

33-46-3. Legislative purposes and intent.

(a) The purpose of this chapter is to promote the delivery of quality healthcare in Georgia. Furthermore, it is to foster the delivery of such care in a cost-effective manner through greater coordination between healthcare providers, claim administrators, insurers, employers, patients, private review agents, and utilization review entities; to improve communication and knowledge of healthcare benefits among all parties; to protect patients, claim administrators, insurers, private review agents, employers, and healthcare providers by ensuring that utilization review activities are based upon accepted standards of treatment and patient care; to ensure that such treatment is accessible and done in a timely and effective manner; and to ensure that private review agents and utilization review entities maintain confidentiality of information obtained in the course of utilization review.

(b) In order to carry out the intent and purposes of this chapter, it is declared to be the policy of this chapter to protect Georgia residents by imposing minimum standards on private review agents and utilization review entities who engage in utilization review with respect to healthcare services provided in Georgia, such standards to include regulations concerning certification of private review agents and utilization review entities, disclosure of utilization review standards and appeal procedures, minimum qualifications for utilization review personnel, minimum standards governing accessibility of utilization review, and such other standards, requirements, and rules or regulations promulgated by the Commissioner which are not inconsistent with the foregoing. Notwithstanding the foregoing, it is neither the policy nor the intent of the General Assembly to regulate the terms of self-insured

employee welfare benefit plans as defined in Section 31(I) of the Employee Retirement Income Security Act of 1974, as amended, and therefore any regulations promulgated pursuant to this chapter shall relate only to persons subject to this chapter.

History.

Code 1981, § 33-46-1, enacted by Ga. L. 1990, p. 1088, § 1; Ga. L. 1996, p. 6, § 33; Code 1981, § 33-46-3, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.

Amendments.

The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-1 as this Code section; substituted "healthcare" for "health care" in four places in subsection (a) and once in subsection (b); in subsection (a), substituted "claim administrators, insurers, employers, patients, private review agents, and utilization review entities" for "claims administrators, payors, employers, patients, and private review agents" and "claim administrators, insurers" for "claims administrators, payors"; and inserted "and utilization review entities" at the end of subsection (a) and twice in the first sentence of subsection (b).

Editor's notes.

Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-3 as present Code Section 33-46-5.

33-46-4. Definitions.

As used in this chapter, the term:

(1) "Adverse determination" means a determination based on medical necessity made by a private review agent or utilization review entity not to grant authorization to a hospital, surgical, or other facility or to a healthcare provider's office for admission, extension of an inpatient stay, or a healthcare service or procedure.

(2) "Authorization" means a determination by a private review agent or utilization review entity that a healthcare service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity.

(3) "Care management organization" means an entity that is organized for the purpose of providing or arranging healthcare, which has been granted a certificate of authority by the Commissioner of Insurance as a health maintenance organization pursuant to Chapter 21 of this title and which has entered into a contract with the Department of Community Health to provide or arrange for healthcare services on a prepaid, capitated basis to members.

(4) "Certificate" means a certificate of registration granted by the Commissioner to a private review agent.

(5) "Claim administrator"' means any entity that reviews and determines whether to pay claims to covered persons on behalf of the healthcare plan. Such payment determinations are made on the basis of contract provisions including medical necessity and other factors. Claim administrators may be insurers or their designated review

organization, self-insured employers, management firms, third-party administrators, or other private contractors.

(6) "Clinical criteria" means the written policies, decisions, rules, medical protocols, or guidelines used by a private review agent or utilization review entity to determine medical necessity.

(7) "Clinical peer" means a healthcare provider who is licensed without restriction or otherwise legally authorized and currently in active practice in the same or similar specialty as that of the treating provider, and who typically manages the medical condition or disease at issue and has knowledge of and experience providing the healthcare service or treatment under review.

(8) "Covered person" means an individual, including, but not limited to, any subscriber, enrollee, member, beneficiary, participant, or his or her dependent, eligible to receive healthcare benefits by a health insurer pursuant to a healthcare plan or other health insurance coverage.

(9) "Emergency healthcare services" means healthcare services rendered after the recent onset of a medical or traumatic condition, sickness, or injury exhibiting acute symptoms of sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(A) Placing the patient's health in serious jeopardy;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(10) "'Facility" means a hospital, ambulatory surgical center, birthing center, diagnostic and treatment center, hospice, or similar institution. Such term shall not mean a healthcare provider's office.

(11) "Health insurer" or "insurer" means an accident and sickness insurer, care management organization, healthcare corporation, health maintenance organization, provider sponsored healthcare corporation, or any similar entity regulated by the Commissioner.

(12) "Healthcare plan" means any hospital or medical insurance policy or certificate, qualified higher deductible health plan, standalone dental plan, health maintenance organization or other managed care subscriber contract, the state health benefit plan, or any plan entered into by a care management organization as permitted by the Department of Community Health for the delivery of healthcare services.

(13) "Healthcare provider" means any person, corporation, facility, or institution licensed by this state or any other state to provide or otherwise lawfully providing healthcare services, including but not limited to a doctor of medicine, doctor of osteopathy, hospital or other healthcare facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, occupational therapist, professional counselor, pharmacist, chiropractor, marriage and family therapist, or social worker.

(14) "Healthcare service" means healthcare procedures, treatments, or services provided by a facility licensed in this state or provided within the scope of practice of a doctor of medicine, a doctor of osteopathy, or another healthcare provider licensed in this state. Such term includes but is not limited to the provision of pharmaceutical products or services or durable medical equipment.

(15) "Medical necessity" or "medically necessary" means healthcare services that a prudent physician or other healthcare provider would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, or disease or its symptoms in a manner that is:

(A) In accordance with generally accepted standards of medical or other healthcare practice;

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration;

(C) Not primarily for the economic benefit of the health insurer or for the convenience of the patient, treating physician, or other healthcare provider; and

(D) Not primarily custodial care, unless custodial care is a covered service or benefit under the covered person's healthcare plan.

(16) "Member" means a Medicaid or PeachCare for Kids recipient who is currently enrolled in a care management organization plan.

(17) "Pharmacy benefits manager" means a person, business entity, or other entity that performs pharmacy benefits management. Such term includes a person or entity acting for a pharmacy benefits manager in a contractual or employment relationship in the performance of pharmacy benefits management for a healthcare plan. Such term shall not include services provided by pharmacies operating under a hospital pharmacy license. Such term shall not include health systems while providing pharmacy services for their patients, employees, or beneficiaries, for indigent care, or for the provision of drugs for outpatient procedures. Such term shall not include services provided by pharmacies affiliated with a facility licensed under Code

Section 31-44-4 or a licensed group model health maintenance organization with an exclusive medical group contract and which operates its own pharmacies which are licensed under Code Section 26-4-110.

(18) "Prior authorization" means any written or oral determination made at any time by a claim administrator or an insurer, or any agent thereof, that a covered person's receipt of healthcare services is a covered benefit under the applicable plan and that any requirement of medical necessity or other requirements imposed by such plan as prerequisites for payment for such services have been satisfied. The term "agent" as used in this paragraph shall not include an agent or agency as defined in Code Section 33-23-1.

(19) "Private review agent" means any person or entity which performs utilization review for:

(A) An employer with employees who are treated by a healthcare provider in this state;

(B) An insurer; or

(C) A claim administrator.

(20) "State health benefit plan" means the health insurance plan or plans established pursuant to Part 6 of Article 17 of Chapter 2 of Title 20 and Article 1 of Chapter 18 of Title 45 for state and public employees, dependents, and retirees.

(21) "Urgent healthcare service" means a healthcare service with respect to which the application of the time periods for making a nonexpedited prior authorization, which, in the opinion of a physician or other healthcare provider with knowledge of the covered person's medical condition:

(A) Could seriously jeopardize the life or health of the covered person or the ability of such person to regain maximum function; or

(B) Could subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

Such term shall include services provided for the treatment of substance use disorders which otherwise qualify as an urgent healthcare service.

(22) "Utilization review" means a system for reviewing the appropriate and efficient allocation or charges of hospital, outpatient, medical, or other healthcare services given or proposed to be given to a patient or group of patients for the purpose of advising the claim administrator who determines whether such services or the charges

therefor should be covered, provided, or reimbursed by an insurer according to the benefits plan. Prior authorization is a type of utilization review. Utilization review shall not include the review or adjustment of claims or the payment of benefits arising under liability, workers' compensation, or malpractice insurance policies as defined in Code Section 33-7-3.

(23) "Utilization review entity" means an insurer or other entity that performs prior authorization for one or more of the following entities:

(A) An insurer that writes health insurance policies;

(B) A preferred provider organization or health maintenance organization; or

(C) Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, behavioral health, prescription drug, or other health benefits to a person treated by a healthcare provider in this state under a health insurance policy, plan, or contract.

(24) "Utilization review plan" means a reasonable description of the standards, criteria, policies, procedures, reasonable target review periods, and reconsideration and appeal mechanisms governing utilization review activities performed by a private review agent or utilization review entity.

History.

Code 1981, § 33-46-2, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-4, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.

Amendments.

The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-2 as this Code section and rewrote the Code section, which read: "As used in this chapter, the term:

"(1) 'Certificate' means a certificate of registration granted by the Commissioner to a private review agent.

"(2) 'Claim administrator' means any entity that reviews and determines whether to pay claims to enrollees of health care providers on behalf of the health benefit plan. Such payment determinations are made on the basis of contract provisions including medical necessity and other factors. Claim administrators may be payors or their designated review organization, self-insured employers, management firms, third-party administrators, or other private contractors.

"(3) 'Commissioner' means the Commissioner of Insurance.

"(4) 'Enrollee' means the individual who has elected to contract for or participate in a health benefit plan for himself or himself and his eligible dependents.

"(5) 'Health benefit plan' means a plan of benefits that defines the coverage provisions for health care for enrollees offered or provided by any organization, public or private.

"(6) 'Health care advisor' means a health care provider licensed in a state representing the claim administrator or private review agent who provides advice on issues of medical necessity or other patient care issues.

"(7) 'Health care provider' means any person, corporation, facility, or institution licensed by this state or any other state to provide or otherwise lawfully providing health care services, including but not limited to a doctor of medicine, doctor of

osteopathy, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, psychologist, occupational therapist, professional counselor, pharmacist, chiropractor, marriage and family therapist, or social worker.

"(8) 'Payor' means any insurer, as defined in this title, or any preferred provider organization, health maintenance organization, self-insurance plan, or other person or entity which provides, offers to provide, or administers hospital, outpatient, medical, or other health care benefits to persons treated by a health care provider in this state pursuant to any policy, plan, or contract of accident and sickness insurance as defined in Code Section 33-7-2.

"(9) 'Private review agent' means any person or entity which performs utilization review for:

"(A) An employer with employees who are treated by a health care provider in this state;

"(B) A payor; or

"(C) A claim administrator.

"(10) 'Reasonable target review period' means the assignment of a proposed number of days for review for the proposed health care services based upon reasonable length of stay standards such as the Professional Activities Study of the Commission on the Professional and Hospital Activities or other Georgia state-specific length of stay data.

"(11) 'Utilization review' means a system for reviewing the appropriate and efficient allocation or charges of hospital, outpatient, medical, or other health care services given or proposed to be given to a patient or group of patients for the purpose of advising the claim administrator who determines whether such services or the charges therefor should be covered, provided, or reimbursed by a payor according to the benefits plan. Utilization review shall not include the review or adjustment of claims or the payment of benefits arising under liability, workers' compensation, or malpractice insurance policies as defined in Code Section 33-7-3.

"(12) 'Utilization review plan' means a reasonable description of the standards, criteria, policies, procedures, reasonable target review periods, and reconsideration and appeal mechanisms governing utilization review activities performed by a private review agent."

Editor's notes.

Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-4 as present Code Section 33-46-6.

33-46-5. Certification of private review agents; exemption.

(a) A private review agent or utilization review entity may not conduct utilization review of healthcare provided in this state unless the Commissioner has granted the private review agent or utilization review entity a certificate pursuant to this chapter. No individual conducting utilization review shall require certification if such utilization review is performed within the scope of such person's employment with an entity already certified pursuant to this Code section.

(b) The Commissioner shall issue a certificate to an applicant that has met all the requirements of this chapter and all applicable regulations of the Commissioner.

(c) A certificate issued under this chapter is not transferable without the prior approval of the Commissioner.

History.

Code 1981, § 33-46-3, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-5, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.

Amendments.

The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-3 as this Code section, and, in the first sentence of subsection (a), inserted "or utilization review entity" in two places and substituted "healthcare" for "health care".

Editor's notes.

Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-5 as present Code Section 33-46-7.

33-46-6. (Effective until January 1, 2026.) Requirements for certification; utilization of nationally recognized accreditation standards; website identifying nationally recognized accreditation entities.

(a) As a condition of certification or renewal thereof, a private review agent or utilization review entity shall be required to maintain compliance with the following:

(1) Where not otherwise addressed in this chapter or department regulations, the medical protocols including reconsideration and appeal processes as well as other relevant medical issues used in the private review or utilization review program shall be established with input from healthcare providers who are from a major area of specialty and certified by the boards of the American medical specialties selected by a private review agency or utilization review entity and documentation of such protocols shall be made available upon request of healthcare providers; or, where not so addressed, protocols, including reconsideration and appeal processes as well as other relevant healthcare issues used in such program, shall be established based on input from persons who are licensed in the appropriate healthcare provider's specialty recognized by a licensure agency of such a healthcare provider;

(2) All preadmission review programs shall provide for immediate hospitalization of any patient for whom the treating healthcare provider determines the admission to be of an emergency nature, so long as medical necessity is subsequently documented;

(3) In the absence of any contractual agreement between the healthcare provider and the insurer, the responsibility for obtaining prior authorization as well as concurrent review required by the insurer shall be the responsibility of the covered person pursuant to Chapter 20E of this title;

(4) In cases where a private review agent or utilization review entity is responsible for utilization review for an insurer or claim administrator, such agent or entity should respond promptly and efficiently in accordance with this chapter to all requests including

concurrent review in a timely method, and a method for an expedited authorization process shall be available in the interest of efficient patient care;

(5) In any instances where the private review agent or utilization review entity is questioning the medical necessity of care, the treating health care provider, or such provider's appropriately qualified designee, shall be able to discuss the plan of treatment with a clinical peer trained in a related specialty and no adverse determination shall be made by the private review agent or utilization review entity until an effort has been made to discuss the patient's care with the patient's treating provider, or such provider's appropriately qualified designee who shall be familiar with the patient's case, during normal working hours. In the event of an adverse determination, notice to the provider will specify the reasons for the review determination;

(6) A private review agent or utilization review entity shall assign a reasonable target review period in accordance with this chapter for each admission promptly upon notification by the healthcare provider. Once a target length of stay has been agreed upon with the healthcare provider, the utilization review agent or utilization review entity will not attempt to contact the healthcare provider or patient for further information until the end of that target review period except for discharge planning purposes or in response to a contact by a patient or healthcare provider. The provider or the healthcare facility will be responsible for alerting the utilization review agent or utilization review entity in the event of a change in proposed treatment. At the end of the target period, the private review agent or utilization review entity will review the care for a continued stay;

(7) A private review agent or utilization review entity shall not enter into any incentive payment provision contained in a contract or agreement with an insurer which is based on reduction of services or the charges thereof, reduction of length of stay, or utilization of alternative treatment settings;

(8) Any healthcare provider may designate one or more individuals to be contacted by the private review agent or utilization review entity for information or data. In the event of any such designation, the private review agent or utilization review entity shall not contact other employees or personnel of the healthcare provider except with prior consent to the healthcare provider. An alternate will be available during normal business hours if the designated individual is absent or unavailable; and

(9) Private review agents and utilization review entities shall develop applicable utilization review plans and conduct utilization

review in accordance with standards as set forth under this chapter and rules and regulations adopted by the Commissioner.

(b) The Commissioner may consider nationally recognized accreditation standards for utilization review and may adopt by rule or regulation any such standards for the purposes of enforcing this chapter, to the extent such standards do not conflict with this chapter.

(c) The Commissioner may maintain on the department website a list of nationally recognized accreditation entities.

History.

Code 1981, § 33-46-4, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-6, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.

Delayed effective date.

Code Section 33-46-6 is set out twice in this Code. This version is effective until January 1, 2026. For version effective January 1, 2026, see the following version.

Amendments.

The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-4 as this Code section and rewrote this Code section, which read: "As a condition of certification or renewal thereof, a private review agent shall be required to maintain compliance with the following:

"(1) The medical protocols including reconsideration and appeal processes as well as other relevant medical issues used in the private review program shall be established with input from health care providers who are from a major area of specialty and certified by the boards of the American medical specialties selected by a private review agency and shall be made available upon request of health care providers; or protocols, including reconsideration and appeal processes as well as other relevant health care issues used in the private review program, shall be established based on input from persons who are licensed in the appropriate health care provider's specialty recognized by a licensure agency of such a health care provider;

"(2) All preadmission review programs shall provide for immediate hospitalization of any patient for whom the treating health care provider determines the admission to be of an emergency nature, so long as medical necessity is subsequently documented;

"(3) In the absence of any contractual agreement between the health care provider and the payor, the responsibility for obtaining precertification as well as concurrent review required by the payor shall be the responsibility of the enrollee;

"(4) In cases where a private review agent is responsible for utilization review for a payor or claim administrator, the utilization review agent should respond promptly and efficiently to all requests including concurrent review in a timely method and a method for an expedited authorization process shall be available in the interest of efficient patient care;

"(5) In any instances where the utilization review agent is questioning the medical necessity or appropriateness of care, the attending health care provider shall be able to discuss the plan of treatment with an identified health care provider trained in a related specialty and no adverse determination shall be made by the utilization review agent until an effort has been made to discuss the patient's care with the patient's attending provider during normal working hours. In the event of an adverse determination, notice to the provider and patient will specify the reasons for the review determination;

"(6) To the extent that utilization review programs are administered according to recognized standards and procedures, efficiently with minimal disruption to the provision of medical care, additional payment to providers should not be necessary;

"(7) A private review agent shall assign a reasonable target review period for each admission promptly upon notification by the health care provider. Once a target

length of stay has been agreed upon with the health care provider, the utilization review agent will not attempt to contact the health care provider or patient for further information until the end of that target review period except for discharge planning purposes or in response to a contact by a patient or health care provider. The provider or the health care facility will be responsible for alerting the utilization review agent in the event of a change in proposed treatment. At the end of the target period, the private review agent will review the care for a continued stay;

"(8) A private review agent shall not enter into any incentive payment provision contained in a contract or agreement with a payor which is based on reduction of services or the charges thereof, reduction of length of stay, or utilization of alternative treatment settings; and

"(9) Any health care provider may designate one or more individuals to be contacted by the private review agent for information or data. In the event of any such designation, the private review agent shall not contact other employees or personnel of the health care provider except with prior consent to the health care provider. An alternate will be available during normal business hours if the designated individual is absent or unavailable."

Editor's notes.

Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-6 as present Code Section 33-46-8.

33-46-6. (Effective January 1, 2026.) Requirements for certification; utilization of nationally recognized accreditation standards; website identifying nationally recognized accreditation entities.

(a) As a condition of certification or renewal thereof, a private review agent or utilization review entity shall be required to maintain compliance with the following:

(1) Where not otherwise addressed in this chapter or department regulations, the medical protocols including reconsideration and appeal processes as well as other relevant medical issues used in the private review or utilization review program shall be established with input from healthcare providers who are from a major area of specialty and certified by the boards of the American medical specialties selected by a private review agency or utilization review entity and documentation of such protocols shall be made available upon request of healthcare providers; or, where not so addressed, protocols, including reconsideration and appeal processes as well as other relevant healthcare issues used in such program, shall be established based on input from persons who are licensed in the appropriate healthcare provider's specialty recognized by a licensure agency of such a healthcare provider;

(2) All preadmission review programs shall provide for immediate hospitalization of any patient for whom the treating healthcare provider determines the admission to be of an emergency nature, so long as medical necessity is subsequently documented;

(3) In the absence of any contractual agreement between the healthcare provider and the insurer, the responsibility for obtaining

prior authorization as well as concurrent review required by the insurer shall be the responsibility of the covered person pursuant to Chapter 20E of this title;

(4) In cases where a private review agent or utilization review entity is responsible for utilization review for an insurer or claim administrator, such agent or entity should respond promptly and efficiently in accordance with this chapter to all requests including concurrent review in a timely method, and a method for an expedited authorization process shall be available in the interest of efficient patient care;

(5) In any instances where the private review agent or utilization review entity is questioning the medical necessity of care, the treating health care provider, or such provider's appropriately qualified designee, shall be able to discuss the plan of treatment with a clinical peer trained in a related specialty and no adverse determination shall be made by the private review agent or utilization review entity until an effort has been made to discuss the patient's care with the patient's treating provider, or such provider's appropriately qualified designee who shall be familiar with the patient's case, during normal working hours. Such effort shall include contacting the treating provider or his or her designee, implementing a callback telecommunications system, or the use of a public website whereby such provider or designee may elect to receive a scheduled communication at a later time in the event that a clinical peer is not available. In the event of an adverse determination, notice to the provider will specify the reasons for the review determination;

(6) A private review agent or utilization review entity shall assign a reasonable target review period in accordance with this chapter for each admission promptly upon notification by the healthcare provider. Once a target length of stay has been agreed upon with the healthcare provider, the utilization review agent or utilization review entity will not attempt to contact the healthcare provider or patient for further information until the end of that target review period except for discharge planning purposes or in response to a contact by a patient or healthcare provider. The provider or the healthcare facility will be responsible for alerting the utilization review agent or utilization review entity in the event of a change in proposed treatment. At the end of the target period, the private review agent or utilization review entity will review the care for a continued stay;

(7) A private review agent or utilization review entity shall not enter into any incentive payment provision contained in a contract or agreement with an insurer which is based on reduction of services or the charges thereof, reduction of length of stay, or utilization of alternative treatment settings;

(8) Any healthcare provider may designate one or more individuals to be contacted by the private review agent or utilization review entity for information or data. In the event of any such designation, the private review agent or utilization review entity shall not contact other employees or personnel of the healthcare provider except with prior consent to the healthcare provider. An alternate will be available during normal business hours if the designated individual is absent or unavailable; and

(9) Private review agents and utilization review entities shall develop applicable utilization review plans and conduct utilization review in accordance with standards as set forth under this chapter and rules and regulations adopted by the Commissioner.

(b) The Commissioner may consider nationally recognized accreditation standards for utilization review and may adopt by rule or regulation any such standards for the purposes of enforcing this chapter, to the extent such standards do not conflict with this chapter.

(c) The Commissioner may maintain on the department website a list of nationally recognized accreditation entities.

History.

Code 1981, § 33-46-4, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-6, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80; Ga. L. 2025, p. 783, § 1/HB 197, effective January 1, 2026.

Delayed effective date.

Code Section 33-46-6 is set out twice in this Code. This version is effective January 1, 2026. For version effective until January 1, 2026, see the preceding version.

Amendments.

The 2025 amendment, effective January 1, 2026, added the second sentence in paragraph (a)(5). See Editor's notes for applicability.

Editor's notes.

Ga. L. 2025, p. 783, § 3/HB 197, not codified by the General Assembly, makes paragraph (a)(5) of this Code section applicable to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after January 1, 2026.

33-46-7. Certificate application fees; information to be submitted with application.

(a) An applicant for a certificate shall submit an application on a form prescribed by the Commissioner and pay an application fee and a certificate fee as provided in Code Section 33-8-1. The application shall be signed and verified by the applicant.

(b) In conjunction with the application, the private review agent or utilization review entity shall submit such information that the Commissioner requires, including but not limited to:

(1) A utilization review plan;

(2) The type and qualifications of the personnel either employed or under contract to perform the utilization review;

(3) A copy of the materials designed to inform applicable patients and healthcare providers of the requirements of the utilization review plan; and

(4) A signed attestation by the chief medical officer or chief executive officer of the applicant that such entity's utilization review activities comply with the standards required by this chapter.

The information provided must demonstrate to the satisfaction of the Commissioner that the applicant will comply with the requirements of this chapter.

History.

Code 1981, § 33-46-5, enacted by Ga. L. 1990, p. 1088, § 1; Ga. L. 1992, p. 2725, § 33; Code 1981, § 33-46-7, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.

Amendments.

The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-5 as this Code section; inserted "or utilization review entity" in subsection (b); deleted "and" at the end of paragraph (b)(2); in paragraph (b)(3), substituted "healthcare" for "health care" and substituted "; and" for a period; added paragraph (b)(4); and substituted "applicant" for "private review agent" in the ending undesignated language of subsection (b).

Editor's notes.

Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-7 as present Code Section 33-46-9.

33-46-8. Expiration and renewal of certificate.

(a) A certificate shall expire on the second anniversary of its effective date unless the certificate is renewed for a two-year term as provided in this Code section.

(b) Before the certificate expires but no sooner than 90 days prior to such expiration, a certificate may be renewed for an additional two-year term if the applicant:

(1) Otherwise is entitled to the certificate;

(2) Pays to the Commissioner the renewal fee as provided in Code Section 33-8-1;

(3) Submits to the Commissioner:

(A) A renewal application on the form that the Commissioner requires; and

(B) Satisfactory evidence of compliance with any requirements established by the Commissioner for certificate renewal; and

(4)(A) Establishes and maintains a complaint system which has

been approved by the Commissioner and which provides reasonable procedures for the resolution of written complaints initiated by covered persons or healthcare providers concerning utilization review;

(B) Maintains records of such written complaints for five years from the time the complaints are filed and submits to the Commissioner a summary report at such times and in such format as the Commissioner may require; and

(C) Permits the Commissioner to examine the complaints at any time.

History.
Code 1981, § 33-46-6, enacted by Ga. L. 1990, p. 1088, § 1; Ga. L. 1992, p. 2725, § 34; Code 1981, § 33-46-8, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.
Amendments.
The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-6 as this Code section and substituted "covered persons or healthcare providers" for "enrollees or health care providers" in subparagraph (b)(4)(A).
Editor's notes.
Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-8 as present Code Section 33-46-10.

33-46-9. Jurisdiction of Commissioner over private review agents and utilization review entities.

Private review agents and utilization review entities shall be subject to the jurisdiction of the Commissioner in all matters regulated by this chapter and the Commissioner shall have such powers and authority with regard to private review agents and utilization review entities as provided in Code Sections 33-2-9 through 33-2-28 with regard to insurers.

History.
Code 1981, § 33-46-7, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-9, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.
Amendments.
The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-7 as this Code section and inserted "and utilization review entities" in two places.
Editor's notes.
Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-9 as present Code Section 33-46-11.

33-46-10. Applicability of Chapter 39 of Title 33.

Private review agents and utilization review entities shall be subject to the provisions of Chapter 39 of this title.

History.
Code 1981, § 33-46-8, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-10, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.
Amendments.
The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-8 as this Code section and inserted "and utilization review entities".

Editor's notes.
Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-10 as present Code Section 33-46-12.

33-46-11. Listings of certificate holders.

The Commissioner shall periodically, not less than once a year, provide a list of private review agents and utilization review entities issued certificates and the renewal date for those certificates to all hospitals and to any other individual or organization requesting such list.

History.
Code 1981, § 33-46-9, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-11, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.
Amendments.
The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-9 as this Code section and inserted "and utilization review entities".
Editor's notes.
Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-11 as present Code Section 33-46-13.

33-46-12. Reporting requirements.

The Commissioner shall establish such reporting requirements upon private review agents and utilization review entities as are necessary to determine if the utilization review programs are in compliance with the provisions of this chapter and applicable rules and regulations.

History.
Code 1981, § 33-46-10, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-12, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.
Amendments.
The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-10 as this Code section and inserted "and utilization review entities".
Editor's notes.
Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-12 as present Code Section 33-46-14.

33-46-13. Adoption of rules and regulations.

The Commissioner shall adopt rules and regulations to implement the provisions of this chapter.

History.
Code 1981, § 33-46-11, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-13, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.
Amendments.
The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-11 as this Code section.
Editor's notes.
Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-13 as present Code Section 33-46-15.

33-46-14. Exemptions from certificate requirements.

No certificate is required for utilization review by any Georgia licensed pharmacist or pharmacy while engaged in the practice of pharmacy, including but not limited to review of the dispensing of drugs, participation in drug utilization review, and monitoring patient drug therapy.

History.
Code 1981, § 33-46-12, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-14, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.
Amendments.
The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-12 as this Code section.
Editor's notes.
Ga. L. 2021, p. 629, § 2/SB 80, effective January 1, 2022, redesignated former Code Section 33-46-14 as present Code Section 33-46-16.

33-46-15. Exemptions from applicability of chapter.

(a) This chapter shall not apply to any contract with the federal government for utilization and review of patients eligible for hospital services under Title XVIII or XIX of the Social Security Act.

(b) This chapter shall not apply to any private review agent or utilization review entity when such private review agent or utilization review entity is working under contract, or an extension or renewal thereof, with a licensed insurer operating under an agreement, providing administrative services pursuant to the provisions of subsection (b) of Code Section 33-20-17 to a healthcare benefit plan negotiated through collective bargaining as that term is defined in the federal National Labor Relations Act, as amended, if the original agreement was executed and in effect prior to January 1, 1990.

(c) This chapter shall not apply to audits of the medical record for the purposes of verifying that healthcare services were ordered and delivered.

History.
Code 1981, § 33-46-13, enacted by Ga. L. 1990, p. 1088, § 1; Code 1981, § 33-46-15, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.
Amendments.
The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-13 as this Code section, inserted "or utilization review entity" in two places in subsection (b), and substituted "healthcare" for "health care" in subsections (b) and (c).

33-46-16. Commissioner to issue annual report.

The Commissioner shall issue an annual report to the Governor and the General Assembly concerning the conduct of utilization review in this state. Such report shall include a description of utilization review

programs and the services they provide, an analysis of complaints filed against private review agents and utilization review entities by patients or providers, and an evaluation of the impact of utilization review programs on patient access to care. The Commissioner shall not be required to distribute copies of the annual report to legislators in the General Assembly but shall notify such legislators of the availability of the report in the manner which he or she deems to be most effective and efficient.

History.

Code 1981, § 33-46-14, enacted by Ga. L. 1990, p. 1088, § 1; Ga. L. 2005, p. 1036, § 26/SB 49; Code 1981, § 33-46-16, as redesignated by Ga. L. 2021, p. 629, § 2/SB 80.

Amendments.

The 2021 amendment, effective January 1, 2022, redesignated former Code Section 33-46-14 as this Code section, inserted "and utilization review entities" in the second sentence, and substituted "annual report to legislators in the General Assembly but shall notify such legislators" for "annual report to the members of the General Assembly but shall notify the members" in the third sentence.

ARTICLE 2

PRIOR AUTHORIZATIONS

Effective date.

This article became effective January 1, 2022. See Editor's notes for applicability.

Editor's notes.

Ga. L. 2021, p. 629, § 1/SB 80, not codified by the General Assembly, provides: "This Act shall be known and may be cited as the 'Ensuring Transparency in Prior Authorization Act.'"

Ga. L. 2021, p. 629, § 3/SB 80, not codified by the General Assembly, provides: "This Act shall become effective on January 1, 2022, and shall apply to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after such date."

33-46-20. Prior authorization requirements posted on website; statistical reporting.

(a) An insurer shall make any current prior authorization requirements readily accessible on its website to healthcare providers. Clinical criteria on which an adverse determination is based shall be provided to the healthcare provider at the time of the notification.

(b) If an insurer intends either to implement a new prior authorization requirement or to amend an existing requirement, such insurer shall ensure that the new or amended requirement is not implemented unless such insurer's website has been updated to reflect such addition or change.

(c) An insurer using prior authorization shall make aggregate statistics available per such insurer and per its plans regarding prior authorization approvals and denials on its website in a readily accessible format. The Commissioner shall determine the statistics required

in order to comply with this Code section in accordance with applicable state and federal privacy laws. Such statistics shall include, but not be limited to, the following:

(1) Approved or denied on initial request;

(2) Reason for denial;

(3) Whether appealed;

(4) Whether approved or denied on appeal; and

(5) Time between submission and response.

History.
Code 1981, § 33-46-20, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-20.1. Program for selective application of reductions in prior authorization requirements.

(a) Each insurer that utilizes prior authorization requirements shall implement and maintain a program that allows for the selective application of reductions in prior authorization requirements based on the stratification of healthcare providers' performance and adherence to evidence based medicine. Such program shall promote quality, affordable healthcare and reduce unnecessary administrative burdens for both the insurer and the healthcare provider.

(b) Criteria for participation by healthcare providers and the healthcare services included in the program shall be at the discretion of the insurer; provided, however, that such insurer shall submit to the department a filing concerning such program. Such filing shall include a full narrative description of the program, the criteria for participation in the program, a list of the procedures and services subject to the program, the number of healthcare providers participating in the program, and any other information deemed necessary by the department.

(c) No later than July 1, 2026, each insurer that utilizes prior authorization requirements shall make the filing provided for in subsection (b) of this Code section, and such filing shall be submitted annually in a form and manner provided for by rules and regulations promulgated by the Commissioner.

History.
Code 1981, § 33-46-20.1, enacted by Ga. L. 2025, p. 783, § 2/HB 197, effective January 1, 2026; Code 1981, § 33-46-20.1, enacted by Ga. L. 2025, p. 773, § 1-1/SB 5, effective July 1, 2025.

Effective date.
This Code section became effective July 1, 2025. See Editor's notes for applicability.

Editor's notes.
Ga. L. 2025, p. 773, § 1-1/SB 5, effective

July 1, 2025, and Ga. L. 2025, p. 783, § 2/HB 197, effective January 1, 2026, enacted identical versions of this Code section.

Ga. L. 2025, p. 773, § 3-1/SB 5, not codified by the General Assembly, provides that this Act shall become effective on July 1, 2025, and shall apply to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after such date.

Ga. L. 2025, p. 783, § 3/HB 197, not codified by the General Assembly, provides that this Act shall become effective on January 1, 2026, and shall apply to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after such date.

33-46-21. Insurer responsibility for compliance; periodic reviews; evaluation of adverse determinations.

(a) An insurer shall be responsible for monitoring all utilization review activities carried out by, or on behalf of, the insurer and for ensuring that all requirements of this chapter and applicable rules and regulations are met. The insurer also shall ensure that appropriate personnel have operational responsibility for the conduct of the insurer's utilization review program.

(b) Whenever an insurer contracts with a private review agent or utilization review entity to perform services subject to this chapter or applicable rules and regulations, the Commissioner shall hold the insurer responsible for monitoring the activities of such private review agent or utilization review entity and for ensuring that the requirements of this chapter and applicable rules and regulations are met.

(c) A private review agent or utilization review entity shall use documented clinical criteria that are based on sound clinical evidence and which are evaluated periodically to assure ongoing efficacy.

(d) Qualified healthcare professionals shall administer the utilization review program and oversee utilization review decisions. An initial screening of prior authorization requests may be completed without providing the treating provider or other qualified healthcare professional with the opportunity to speak with a clinical peer of the private review agent or utilization review entity. Such an opportunity shall be provided, however, before an appeal. If a private review agent or utilization review entity questions the medical necessity of a healthcare service, such agent or entity shall notify the covered person's treating provider, or such provider's appropriately qualified designee familiar with the patient's case, that medical necessity is being questioned in accordance with the provisions of paragraph (5) of subsection (a) of Code Section 33-46-6.

(e) An insurer shall provide covered persons and participating providers with access to its utilization review staff by telephone or through synchronous digital text or voice messaging or similar technology in accordance with state and federal privacy laws. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.

History.
Code 1981, § 33-46-21, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-22. Review of appeals by appropriate healthcare provider.

A private review agent or utilization review entity shall ensure that all appeals are reviewed by an appropriate healthcare provider who shall:

(1) Possess a current and valid nonrestricted license or maintain other appropriate legal authorization;

(2) Be currently in active practice in the same or similar specialty and who typically manages the medical condition or disease;

(3) Be knowledgeable of, and have experience providing, the healthcare service under appeal;

(4) Not have been directly involved in making the adverse determination; and

(5) Consider all known clinical aspects of the healthcare service under review, including, but not limited to, a review of all pertinent medical or other records provided to the private review agent or utilization review entity by the covered person's healthcare provider, any relevant records provided to such agent or entity by a facility, and any medical or other literature provided to such agent or entity by the healthcare provider.

History.
Code 1981, § 33-46-22, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-23. Restrictions on authorizations when service timely rendered.

If initial healthcare services are performed within 45 business days of approval of prior authorization, the insurer shall not revoke, limit, condition, or restrict such authorization, unless such prior authorization is for a Schedule II controlled substance or there is a billing error, fraud, material misrepresentation, or loss of coverage.

History.
Code 1981, § 33-46-23, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-23.1. Prior authorization of prescription medications for chronic conditions.

(a) As used in this Code section, the term:

(1) "Chronic condition" means a serious, long-term, physical, mental, or developmental disability or disease.

(2) "Ongoing medication therapy" means a clinical and evidence-based treatment that uses a prescribed medicine to prevent, diagnose, treat, or relieve the symptoms of a chronic condition and is continuing or expected to continue for at least a year.

(b) Unless otherwise provided in subsection (c) of this Code section or prohibited by state or federal law, if a healthcare provider receives a prior authorization for a medication prescribed to a covered person with a chronic condition that requires ongoing medication therapy, and the provider continues to prescribe the medication, and the medication is used for a condition that is within the scope of use approved by the United States Food and Drug Administration or has been proven to be a safe and effective form of treatment for the patient's specific underlying condition based on clinical practice guidelines that are developed from peer-reviewed publications, the prior authorization received shall:

(1) Be valid for the lesser of:

(A) One year from the date the healthcare provider receives the prior authorization; or

(B) Until the last day of coverage under the covered person's healthcare plan; and

(2) Cover any change in dosage prescribed by the healthcare provider during the period of authorization.

(c)(1) This Code section shall not apply to:

(A) Medications that are prescribed for a nonmaintenance condition;

(B) Medications that have a typical treatment period of less than 12 months;

(C) Medications for which medical or scientific evidence does not support a 12 month approval, including medications where an initial shorter duration approval is necessary to demonstrate appropriate response to therapy; or

(D) Medications that are opioid analgesics or benzodiazepines.

(2) Nothing in this Code section prevents the prior authorization of a medication for more than a year if permissible by the covered person's healthcare plan.

History.
Code 1981, § 33-46-23.1, enacted by Ga. L. 2022, p. 594, § 1/SB 341.
Effective date.
This Code section became effective January 1, 2023. See Editor's notes for applicability.
Editor's notes.
Ga. L. 2022, p. 594, § 2/SB 341, not codified by the General Assembly, makes this Code section applicable to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after January 1, 2023.

33-46-24. Medically necessary unanticipated emergency or urgent healthcare services.

Prior authorization shall not be required for unanticipated emergency healthcare services, urgent healthcare services, or covered healthcare services which are incidental to the primary covered healthcare service and determined by the covered person's physician or dentist to be medically necessary.

History.
Code 1981, § 33-46-24, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-25. Prior authorization for ambulance transportation or emergency healthcare services prohibited.

An insurer cannot require prior authorization for emergency prehospital ambulance transportation or for the provision of emergency healthcare services.

History.
Code 1981, § 33-46-25, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-26. Timely notification of prior authorization or adverse determination.

Effective January 1, 2022, until December 31, 2022, if an insurer requires prior authorization of a healthcare service, a private review agent or utilization review entity shall notify the covered person's healthcare provider, or such provider's appropriately qualified designee, of any prior authorization or adverse determination within 15 calendar days of obtaining all necessary information to make such authorization or adverse determination. Effective January 1, 2023, if an insurer requires prior authorization of a healthcare service, a private review agent or utilization review entity shall notify the covered person's healthcare provider, or such provider's appropriately qualified designee, of any prior authorization or adverse determination within 7 calendar days of obtaining all necessary information to make such authorization or adverse determination.

History.
Code 1981, § 33-46-26, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-27. Notification time for prior authorization or adverse determination.

A private review agent or utilization review entity shall render a prior authorization or adverse determination concerning urgent healthcare services and notify such person's healthcare provider, or such provider's appropriately qualified designee, of that prior authorization or adverse determination no later than 72 hours after receiving all information needed to complete the review of the requested healthcare services.

History.
Code 1981, § 33-46-27, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-28. Honoring of prior authorizations.

(a) Upon receipt of information documenting a prior authorization from a covered person or from a covered person's healthcare provider, a private review agent or utilization review entity, for at least the initial 30 days of such person's new coverage, shall honor a prior authorization for a covered healthcare service granted to him or her from a previous private review agent or utilization review entity even if approval criteria or products of a healthcare plan have changed or such person is covered under a new healthcare plan, so long as the former criteria, products, or plans are not binding upon a new insurer.

(b) During the time period described in subsection (a) of this Code section, a private review agent or utilization review entity may perform its own review to grant a prior authorization.

(c) If there is a change in coverage of, or approval criteria for, a previously authorized healthcare service, the change in coverage or approval criteria shall not affect a covered person who received prior authorization before the effective date of such change for the remainder of the covered person's plan year so long as such person remains covered by the same insurer.

(d) A private review agent or utilization review entity shall continue to honor a prior authorization it has granted to a covered person in accordance with this Code section.

History.
Code 1981, § 33-46-28, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-29. Noncompliance resulting in automatic authorization.

Each violation by a private review agent or utilization review entity of deadline or other requirements specified in this chapter shall result in the automatic authorization of healthcare services under review by such private review agent or utilization review entity if such noncompliance is related to such services. Notwithstanding the foregoing, noncompliance based on a de minimis violation that does not cause, or is not likely to cause, prejudice or harm to the covered person shall not result in the automatic authorization of such healthcare services, so long as the insurer demonstrates that the violation occurred due to good cause or due to matters beyond the control of the insurer and that such violation occurred in the context of an ongoing good faith exchange of information between the insurer and the covered person, or, if applicable, the covered person's healthcare provider or authorized representative.

History.
Code 1981, § 33-46-29, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-30. Mandatory compliance.

With regard to the provision of healthcare services, each contract entered into or renewed by a managed care organization, each contract entered into or renewed by the Department of Community Health with a care management organization, and each contract entered into by the board of such organization with a contracted entity pursuant to the state health benefit plan shall comply with this chapter.

History.
Code 1981, § 33-46-30, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-31. Role of Commissioner; compliance enforced by Department of Community Health.

The Commissioner shall not have the authority to approve, disapprove, or modify any plan offered by a care management organization or any contract between a care management organization and the Department of Community Health. Compliance with this chapter by care management organizations shall be enforced by the Department of Community Health.

History.
Code 1981, § 33-46-31, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

33-46-32. Commissioner's authority not reduced.

Nothing in this chapter shall be construed as reducing the authority of the commissioner of community health.

History.
Code 1981, § 33-46-32, enacted by Ga. L. 2021, p. 629, § 2/SB 80.

CHAPTER 52

ASSUMPTION REINSURANCE AGREEMENTS AND INSURANCE BUSINESS TRANSFERS

Article 1

Assumption Reinsurance Agreements

Sec.
33-52-1. Applicability of article.
33-52-2. Definitions.
33-52-4. Rejection of transaction by policyholders; receipt of notice; transfers involving companies deemed to be in hazardous condition.

Article 2

Insurance Business Transfers

33-52-10. Short title.
33-52-11. Purpose of article.
33-52-12. Definitions.
33-52-13. Court action not precluded.
33-52-14. Notice requirements.
33-52-15. Application to Commissioner; petition to and approval by court; rules and regulations; confidentiality.
33-52-16. Consent to jurisdiction.
33-52-17. Fees; reimbursement of expenses; penalty for non-payment.

ARTICLE 1

ASSUMPTION REINSURANCE AGREEMENTS

Editor's notes.
Ga. L. 2024, p. 770, § 2/HB 1049, not codified by the General Assembly, designated Code Sections 33-52-1 through 33-52-6 as Article 1.

33-52-1. Applicability of article.

(a) This article shall apply to any insurer authorized or doing business in this state which transfers or assumes the obligations or risks on contracts of insurance written or assumed in this state to or from another insurer pursuant to an assumption reinsurance agreement.

(b) This article shall not apply to:

(1) Any reinsurance agreement or transaction in which the ceding insurer continues to remain directly liable for its insurance obligations or risks under the contracts of insurance subject to the reinsurance agreement;

(2) The substitution of one insurer for another upon expiration of insurance coverage pursuant to statutory or contractual requirements and the issuance of a new contract of insurance by another insurer;

(3) The transfer of contracts of insurance pursuant to mergers or consolidations of two or more insurers to the extent that those transactions are regulated by statute;

(4) Any insurer subject to a judicial order of liquidation or rehabilitation; or

(5) Any contract controlled by a state guaranty association or a state insolvency pool.

History.
Code 1981, § 33-52-1, enacted by Ga. L. 1992, p. 1385, § 1; Ga. L. 2024, p. 770, § 3/HB 1049, effective May 6, 2024.

Amendments.
The 2024 amendment, effective May 6, 2024, substituted "article" for "chapter" in subsection (a) and at the beginning of subsection (b).

33-52-2. Definitions.

As used in this article:

(1) "Assuming insurer" means the insurer which acquires an insurance obligation or risk from the transferring insurer pursuant to an assumption reinsurance agreement.

(2) "Assumption reinsurance agreement" means any contract which both:

(A) Transfers insurance obligations or risks of existing or in-force contracts of insurance from a transferring insurer to an assuming insurer; and

(B) Is intended to effect a novation of the transferred contract of insurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks under such contracts are extinguished.

(3) "Contract of insurance" means any written agreement between an insurer and policyholder pursuant to which the insurer, in

exchange for a premium or other consideration, agrees to assume an obligation or risk of the policyholder or to make payments on behalf of or to the policyholder or its beneficiaries; it shall include all property, casualty, life, health, accident, accident and sickness, surety, title, and annuity business authorized to be written pursuant to the provisions of this title.

(4) "Notice of transfer" means the written notice to policyholders required by subsection (a) of Code Section 33-52-3.

(5) "Policyholder" means any individual or entity which has the right to terminate or otherwise alter the terms of a contract of insurance. It includes any person issued a group certificate under a group insurance contract if the certificate vests in such person, separate from the rights of the group contract holder, rights against the insurer that the group contract holder may not terminate. The right to keep the policy in force referred to in this article shall not include the right to elect individual coverage under the federal consolidated Omnibus Budget Reconciliation Act (COBRA) Section 601, et seq., of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. Section 1161, et seq., or under continuation and conversion provisions found in Chapter 24 of this title.

(6) "Transferring or ceding insurer" means the insurer which transfers or cedes an insurance obligation or risk to an assuming insurer pursuant to an assumption reinsurance agreement.

History.

Code 1981, § 33-52-2, enacted by Ga. L. 1992, p. 1385, § 1; Ga. L. 2024, p. 770, § 3/HB 1049, effective May 6, 2024.

Amendments.

The 2024 amendment, effective May 6, 2024, substituted "article" for "chapter" in the introductory language and in the third sentence in paragraph (5).

33-52-4. Rejection of transaction by policyholders; receipt of notice; transfers involving companies deemed to be in hazardous condition.

(a) Every policyholder shall have the right to reject the transfer and novation of his or her contract of insurance. Policyholders electing to reject the assumption transaction shall provide the transferring insurer with the pre-addressed, postage-paid response card or other written notice that the assumption is rejected no later than 60 days after the date on which the transferring insurer mails the notice required under subsection (a) of Code Section 33-52-3. If the ceding insurer does not receive written rejection within the 60 day period, it shall send a second notice in accordance with subsection (a) of Code Section 33-52-3. If the ceding insurer does not receive a rejection within 30 days after the date

of mailing, the policyholder shall be deemed to have accepted the transfer.

(b) The transferring insurer will be deemed to have received the response card or other written notice on the date it is postmarked. A policyholder may also send its response card or other written notice by facsimile or other electronic transmission or by certified mail or statutory overnight delivery, express delivery, personal delivery, or courier service, in which case the response card or other written notice shall be deemed to have been received by the assuming insurer on the date of actual receipt by the transferring insurer.

(c) If the transferring company is deemed by the Commissioner to be in hazardous condition or is under a supervision order, rehabilitation, liquidation, conservation, or receivership and the transfer of policies is in the best interest of the policyholders as determined by the Commissioner, a transfer may be effected notwithstanding the provisions of this article. This may include adequate notification to the policyholder of the circumstances requiring the transfer as approved by the Commissioner.

History.
Code 1981, § 33-52-4, enacted by Ga. L. 1992, p. 1385, § 1; Ga. L. 2000, p. 1589, § 3; Ga. L. 2024, p. 770, § 3/HB 1049, effective May 6, 2024.

Amendments.
The 2024 amendment, effective May 6, 2024, substituted "article" for "chapter" at the end of the first sentence in subsection (c).

ARTICLE 2

INSURANCE BUSINESS TRANSFERS

Effective date.
This article became effective May 6, 2024.

33-52-10. Short title.

This article shall be known and may be cited as the "Insurance Business Transfer Act."

History.
Code 1981, § 33-52-10, enacted by Ga. L. 2024, p. 770, § 4/HB 1049, effective May 6, 2024.

Code Commission notes.
Pursuant to Code Section 28-9-5, in 2024, "article" was substituted for "Act" near the beginning of this Code section.

33-52-11. Purpose of article.

This article is adopted to provide options to address the limitations in the current methods available to insurers to transfer or assume blocks of insurance business in an efficient and cost-effective manner that: provides needed legal finality for such transfers in order to provide for improved operational and capital efficiency for insurance companies;

stimulates the economy by attracting segments of the insurance industry to this state; makes this state an attractive home jurisdiction for insurance companies; encourages economic growth and increased investment in the financial services sector; and increases the availability of quality insurance industry jobs in this state. These purposes are accomplished by providing a basis and procedures for the transfer and novation of policies from a transferring insurer to an assuming insurer by way of an insurance business transfer plan without the affirmative consent of policyholders or reinsureds. The novation is effected by court order. This article establishes the requirements for notice and disclosure and standards and procedures for the approval of the transfer and novation by the Commissioner and the Superior Court of Fulton County pursuant to an insurance business transfer plan. This article shall not limit or restrict other means of effecting a transfer or novation.

History.
Code 1981, § 33-52-11, enacted by Ga. L. 2024, p. 770, § 4/HB 1049, effective May 6, 2024.

33-52-12. Definitions.

As used in this article, the term:

(1) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.

(2) "Applicant" means an assuming insurer, transferring insurer, or reinsurer applying to the Commissioner for the approval of an insurance business transfer plan as provided for in Code Section 33-52-15.

(3) "Approval order" means an order issued by the court approving an insurance business transfer plan as provided for in Code Section 33-52-15.

(4) "Assuming insurer" means an insurer domiciled in this state that assumes or seeks to assume policies from a transferring insurer pursuant to this article. An assuming insurer may be a company established pursuant to Chapter 41 of this title.

(5) "Court" means the Superior Court of Fulton County.

(6) "Implementation order" means an order issued by the court implementing an insurance business transfer plan as provided for in Code Section 33-52-15.

(7) "Independent expert" means an impartial individual who assists the Commissioner and the court in connection with their review of a proposed transfer and novation of insurance business. The Commissioner shall select such expert from a list of at least two

nominees submitted jointly by the transferring insurer and the assuming insurer; provided, however, that, if the Commissioner, in his or her sole discretion, rejects such nominees, the Commissioner may appoint another person to serve as an independent expert. An independent expert or nominee shall:

(A) Hold no financial interest in either the assuming insurer or transferring insurer or any of their respective affiliates;

(B) Not have been employed by or acted as an officer, director, consultant, or other independent contractor for either the assuming insurer or transferring insurer within the previous twelve months;

(C) Not be simultaneously appointed by the Commissioner to assist in any capacity in any insurer rehabilitation or delinquency proceeding;

(D) Not receive or be promised compensation in connection with the insurance business transfer for which he or she is selected to serve as an independent expert; provided, however, that a fee may be approved by the Commissioner that is not contingent upon the approval, implementation, or consummation of an insurance business transfer plan; and

(E) Provide proof of insurance covering the services provided as an independent expert as determined by the Commissioner.

(8) "Insurance business transfer" means a transfer and novation in accordance with this article. An approved insurance business transfer transfers insurance obligations, risks, rights, or any combination thereof, of existing or in-force contracts of insurance or reinsurance from a transferring insurer to an assuming insurer. An approval order and an implementation order of an insurance business transfer plan will effect a transfer and novation of the transferred contracts of insurance or reinsurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations, risks, rights, or any combination thereof, under the contracts are extinguished.

(9) "Insurance business transfer plan" or "plan" means the plan submitted to the department to accomplish the transfer and novation pursuant to an insurance business transfer, including any associated transfer of assets and rights from or on behalf of the transferring insurer to the assuming insurer.

(10) "Insurer" means an insurance or surety company, including a reinsurance company, and includes a corporation, company, partnership, association, society, order, individual, or aggregation of indi-

viduals engaging in or proposing or attempting to engage in any kind of insurance or surety business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships, and corporations.

(11) "Notice" means written notice, telephone notice, electronic notice, or substitute notice, as consented to in an agreement included in or related to the subject business, or as provided by rules and regulations promulgated by the Commissioner.

(12) "Petitioner" means an assuming insurer, transferring insurer, or reinsurer petitioning a court for an approval order and an implementation order of a plan pursuant to this article.

(13) "Policy" means a policy, contract or certificate of insurance or a contract of reinsurance pursuant to which an insurer agrees to assume an insurance obligation or risk, or both, of a policyholder or to make payments on behalf of, or to, such policyholder or its beneficiaries, and shall include property, casualty, life, health, and any other line of insurance the Commissioner deems appropriate for an insurance business transfer.

(14) "Policyholder" means an insured or a reinsured under a policy that is part of the subject business.

(15) "State insurance guaranty association" means the Georgia Insurers Insolvency Pool, created by Chapter 36 of this title, the Georgia Life and Health Insurance Guaranty Association, created by Chapter 38 of this title, or any similar organization in another state.

(16) "Subject business" means the policy or policies designated for transfer and novation pursuant to a corresponding insurance business transfer plan.

(17) "Transfer and novation" means the transfer of insurance obligations, risks, rights, or any combination thereof, of existing or in-force policies from a transferring insurer to an assuming insurer, with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer on the transferred policies and the transferring insurer's insurance obligations, risks, rights, or any combination thereof, under the transferred policies are extinguished.

(18) "Transferring insurer" means an insurer or reinsurer that seeks to or has accomplished a transfer and novation of insurance obligations, risks, rights, or any combination thereof, under one or more policies to an assuming insurer pursuant to an insurance business transfer plan and the provisions of this article.

History. Code 1981, § 33-52-12, enacted by Ga. L. 2024, p. 770, § 4/HB 1049, effective May 6, 2024.

33-52-13. Court action not precluded.

Notwithstanding any other provision of law, the court may issue any order, process, or judgment it deems necessary or appropriate to carry out the provisions of this article. No provision of this article shall be construed to preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of power.

History. Code 1981, § 33-52-13, enacted by Ga. L. 2024, p. 770, § 4/HB 1049, effective May 6, 2024.

33-52-14. Notice requirements.

(a) When notice is required under this article and except as otherwise permitted or directed by the court or the Commissioner, such notice shall be transmitted within 45 days of the event triggering such requirement:

(1) To the chief insurance regulatory official in each jurisdiction in which the transferring insurer:

(A) Holds or has ever held a certificate of authority; and

(B) In which policies that are part of the subject business were issued or policyholders currently reside;

(2) To the National Conference of Insurance Guaranty Funds, the National Organization of Life and Health Insurance Guaranty Associations, and all state insurance guaranty associations for the states in which the transferring insurer:

(A) Holds or has ever held a certificate of authority; and

(B) In which policies that are part of the subject business were issued or policyholders currently reside;

(3) To reinsurers of the transferring insurer pursuant to the notice provisions of the reinsurance agreements applicable to the policies that are part of the subject business, or where an agreement has no provision for notice, by internationally recognized delivery service;

(4) To all policyholders holding policies that are part of the subject business at their last known address as indicated by the records of the transferring insurer or to the address to which premium notices or other policy documents are sent. Notice shall also be sent to the transferring insurer's agents or brokers of record on the subject business; and

(5) By publication in a newspaper or other publication of general circulation in the state in which the transferring insurer has its principal place of business and in such other publications that the Commissioner requires.

(b) When notice is given in accordance with this Code section, any information or orders under this article shall be conclusive with respect to all intended recipients of the notice, whether or not the intended recipients receive actual notice.

(c) When notice is required by an applicant or petitioner but a receiver of the insurer has been appointed pursuant to the laws of the insurer's home jurisdiction, the receiver shall provide the required notice.

History. Code 1981, § 33-52-14, enacted by Ga. L. 2024, p. 770, § 4/HB 1049, effective May 6, 2024.

33-52-15. Application to Commissioner; petition to and approval by court; rules and regulations; confidentiality.

(a) **Application to the Commissioner for approval of an insurance business transfer plan.**

(1) An insurance business transfer plan shall be filed by the applicant with the Commissioner for review and approval. The plan shall contain the information set forth below or an explanation as to why such information is not included. The plan may be supplemented or revised with additional, updated, or other information when deemed necessary by the Commissioner and as it becomes available:

(A) The name, address, and telephone number of the transferring insurer and the assuming insurer and their respective direct and indirect controlling persons, if any;

(B) A summary of the insurance business transfer plan;

(C) Identification and description of the subject business;

(D) The most recent audited financial statements and annual and quarterly reports of the transferring insurer and assuming insurer filed with their respective domiciliary regulator;

(E) The most recent actuarial report and actuarial opinion that quantify the liabilities associated with the subject business;

(F) Pro-forma financial statements showing the projected statutory balance sheet, results of operations, and cash flows of the assuming insurer for the three years following the proposed transfer and novation;

(G) Officers' certificates of the transferring insurer and the

assuming insurer attesting that each has obtained all required internal approvals and authorizations regarding the insurance business transfer plan and completed all necessary and appropriate actions relating thereto;

(H) Proposal for plan implementation and administration;

(I) Form of notice to be provided under the plan to any policyholder whose policy is part of the subject business, including a full description as to how such notice shall be provided and whether certificates of assumption shall be issued to policyholders;

(J) Description of any reinsurance arrangements that will pass to the assuming insurer under the insurance business transfer plan;

(K) Description of any guarantees or additional reinsurance that will cover the subject business following the transfer and novation;

(L) A statement describing the assuming insurer's proposed investment policies and any contemplated third-party claims management and administration arrangements;

(M) A statement of whether any policyholder or group of policyholders shall lose or gain coverage of a state insurance guaranty association and a description of how the transferring and assuming insurers shall be licensed for the purpose of state insurance guaranty association coverage;

(N) Evidence of approval or nonobjection of the transfer from the chief insurance regulatory official of the jurisdiction of the transferring insurer's domicile; and

(O) An opinion report from an independent expert. Such report shall provide the following:

(i) A statement of the independent expert's professional qualifications and experience that qualify him or her as an expert suitable for the engagement;

(ii) The scope of the report;

(iii) A summary of the terms of the insurance business transfer plan relevant to the report;

(iv) A list of and summaries for documents, reports, and other material information the independent expert has considered in preparing the report and whether any information requested was not provided;

(v) The extent to which the independent expert has relied on information and judgment provided by others;

(vi) The persons upon whom the independent expert has relied and why such reliance is reasonable;

(vii) The independent expert's opinion of the likely effects of the insurance business transfer plan on policyholders, reinsurers, and claimants, distinguishing between:

(I) Transferring policyholders, reinsurers, and claimants;

(II) Policyholders, reinsurers, and claimants of the transferring insurer whose policies will not be transferred; and

(III) Policyholders, reinsurers, and claimants of the assuming insurer;

(viii) For each opinion that the independent expert expresses in the report, the facts and circumstances supporting such opinion; and

(ix) Consideration as to whether the security position of any policyholder or group of policyholders affected by the insurance business transfer are materially adversely affected by the transfer, including, but not limited to, coverage by a state insurance guaranty association.

(2) The independent expert's opinion report as required by subparagraph (a)(1)(O) of this Code section shall include, but shall not be limited to, a review of the following:

(A) Analysis of the transferring insurer's actuarial review of reserves for the subject business to determine the reserve adequacy;

(B) Analysis of the financial condition of the transferring insurer and of the assuming insurer and the effect the insurance business transfer shall have on the financial condition of each insurance company;

(C) The plans or proposals the assuming insurer has with respect to the administration of the subject business;

(D) Whether the proposed transfer will likely have a material adverse effect on the policyholders, reinsurers, or claimants of the transferring insurer and the assuming insurer;

(E) Analysis of the assuming insurer's corporate governance structure to ensure proper board and management oversight and expertise to manage the subject business; and

(F) Any other information the Commissioner deems necessary to review the insurance business transfer plan.

(3) The Commissioner shall have 60 business days from the date of receipt of a complete insurance business transfer plan to review such

plan to determine if the applicant is authorized to submit such plan to the court. The Commissioner may extend such review period for an additional 30 business days.

(4) The Commissioner shall authorize the submission of the plan to the court unless he or she finds that the insurance business transfer will likely have a material adverse effect on the interests of policyholders, reinsurers, or claimants that are part of the subject business.

(5) When the Commissioner determines that the insurance business transfer will likely have a material adverse effect on the interests of policyholders, reinsurers, or claimants that are part of the subject business, the Commissioner shall notify the applicant and specify any modifications, supplements, or amendments, and any additional information or documentation with respect to the plan that shall be provided to the Commissioner before he or she will authorize the filing of such insurance business transfer plan with the court.

(6) The applicant shall have 30 days from the date the Commissioner notifies him or her, as provided in paragraph (5) of this subsection, to file an amended plan providing the modifications, supplements, or amendments, and additional information or documentation as requested by the Commissioner. If necessary, the applicant may request in writing an extension of up to 30 days. If the applicant does not make an amended filing within the time period provided for in this paragraph, including any extension of time granted by the Commissioner, the plan filing shall terminate and a subsequent filing by the applicant shall be considered a new filing which shall require compliance with all provisions of this article as if the prior filing had never been made.

(7) The Commissioner's review period provided for in paragraph (3) of this subsection shall recommence upon receipt of the amended plan providing the modification, supplement, amendment, and the additional information or documentation requested in paragraph (5) of this subsection.

(8) When the Commissioner authorizes the applicant to proceed with filing a petition with the court seeking approval and implementation of the plan, the Commissioner shall confirm such determination in writing to the applicant.

(b) **Petition to the court for approval of the insurance business transfer plan and an implementation order.**

(1) Within 30 days of the Commissioner's order determining an insurance business transfer plan satisfies the requirements of this

article, the assuming insurer, transferring insurer, or reinsurer may file a petition with the court seeking an approval order and an implementation order of such plan. Upon written request by the applicant to the Commissioner, the period for filing a petition with the court may be extended for an additional 30 days.

(2) The petition provided for in paragraph (1) of this subsection shall include:

(A) The relief sought;

(B) Information, arguments, and authorities supporting the requested relief, including information and analysis in support of the court's finding that the plan will not likely have a material adverse effect to any policyholder, reinsurer, or claimant;

(C) The insurance business transfer plan;

(D) A preliminary list of witnesses and exhibits that the petitioner reasonably intends to present to the court; and

(E) A request for the court to enter judgment in favor of the petitioner and that such judgment shall include findings of fact, conclusions of law, an approval order, an implementation order, and the court's retention of jurisdiction to allow the parties to request any orders regarding incidental, consequential, and supplementary matters necessary to assure the full and effective implementation of such plan.

(3) The Commissioner shall be a party to the proceeding before the court concerning the petition and shall be served with copies of all filings. The Commissioner's position in the proceeding shall not be limited by his or her initial review of the plan.

(4) Within 30 days after the filing of the petition provided for in paragraph (1) of this subsection, the petitioner shall file a request for a preliminary scheduling order, which shall include a date and time for a status conference. The status conference shall occur no fewer than 14 days after the conclusion of the 60 day comment period provided in paragraph (7) of this subsection.

(5) Within 45 days after the court enters the preliminary scheduling order, the petitioner shall cause the transmission and publication of a notice of the matter before the court in accordance with the notice provisions of Code Section 33-52-14.

(6) The notice provided for in paragraph (5) of this subsection shall include:

(A) The date and time of the status conference;

(B) The name, address and telephone number of the assuming insurer, transferring insurer, and Commissioner;

(C) A statement regarding whether any policyholder or group of policyholders may or shall lose or gain coverage by a state insurance guaranty association as a result of the transfer and the implication of losing or gaining such coverage;

(D) Procedures and deadlines for policyholders, claimants, and third parties to submit comments, objections, or requests to be heard at the trial regarding the plan;

(E) The procedure for a policyholder that is unable to access or acquire an electronic copy of the plan and associated information to request the petitioner to provide one free hard copy to a policyholder;

(F) A summary of the order entered by the Commissioner, including the effect the plan shall have on policyholders, if any;

(G) The name and location of the court in which the petition is filed;

(H) The case number, parties, and other identifying information of the matter in the petition;

(I) The relief sought in the petition;

(J) The procedure to access an electronic copy of the insurance business transfer plan and associated information, if any;

(K) Further notice of filings, schedules, orders, and other information, as provided in paragraph (9) of this subsection; and

(L) If the plan is approved by the court, the court shall enter a judgment consistent with paragraph (3) of subsection (c) of this Code section.

(7) The last date of the transmission and publication of the notice shall be followed by a comment period of no fewer than 60 days.

(8) Any person, including by their legal representative, that provides written notice within the 60 day comment period provided for in paragraph (7) of this subsection and that asserts to be materially adversely affected by the approval and implementation of a plan may present comment or evidence to the court at the trial; provided, however, that such comment or evidence shall not confer standing as a party on any person. Any person participating in the pretrial proceeding or the trial of the petitioner's request for an order of approval and an implementation order of the plan shall follow the process established by the court and shall bear their own costs and attorney's fees.

(9) Only parties to this matter and those persons and other third parties that file a request to provide comment or evidence as provided

for in paragraph (8) of this subsection shall receive further notice and copies of filings with the court.

(10) Within 45 days of the status conference required as provided for in paragraph (4) of this subsection, the petitioner shall file a motion for a scheduling order and to enter this matter on the court's trial docket.

(c) **Approval order by the court of an insurance business transfer plan and implementation order.**

(1) Pursuant to the court's scheduling order or other orders by the court, the petitioner shall present the insurance business transfer plan, evidence, and arguments to the court for approval and implementation of the plan.

(2) At any time before the court issues a judgment, the petitioner may withdraw the petition without prejudice to refiling.

(3) When the court finds that the approval and implementation of the insurance business transfer plan will not materially adversely affect the interests of policyholders or claimants to policies that are part of the subject business, the court shall enter judgment in favor of the petitioner and an implementation order. Such judgment and order shall include and provide for:

(A) Findings of fact;

(B) Conclusions of law;

(C) The approval order and the implementation order, including:

(i) The simultaneous transfer and novation from the transferring insurer to the assuming insurer of the subject business with respect to all policyholders, reinsurers, and claimants and their respective policies and reinsurance agreements under the subject business;

(ii) The simultaneous transfer and novation from the transferring insurer and the assuming insurer of all insurance obligations, risks, rights, or any combination thereof, including, but not limited to, the ceded reinsurance of transferred policies and contracts included in the subject business, notwithstanding any non-assignment provisions in any such reinsurance contracts or other agreements;

(iii) Documentation that the assuming insurer shall have all of transferring insurer's obligations, risks, rights, or any combination thereof, regarding the subject business as if it were the original insurer of such policies, including the same standing as the transferring insurer pursuant to contract, statute, and interpretation, relating back to the issuance of such policies; and

(iv) Documentation that the policyholders' and claimants' obligations, risks, rights, or any combination thereof, if any, under their respective policies which are part of the subject business shall not be enlarged, extended, limited, or reduced; provided, however, that the policyholders and claimants may not pursue or be pursued by the transferring insurer to satisfy their respective obligations, risks, rights, or any combination thereof, but rather, the policyholders and claimants may pursue or be pursued by the assuming insurer;

(D) Notice of such judgment, including the resulting transfer and novation, shall be provided by the petitioner in accordance with the notice requirements as provided in Code Section 33-52-14;

(E) Other orders and provisions with respect to incidental, consequential, and supplementary matters as are necessary to assure full and effective implementation of the insurance business transfer plan; and

(F) The retention of jurisdiction of the matter so as to allow the parties to request such additional orders regarding incidental, consequential, and supplemental matters necessary to assure the full and effective implementation of the plan.

(4) When the court finds that the insurance business transfer plan should not be approved, the court by its order may:

(A) Deny the petition; or

(B) Provide the petitioner leave to file an amended petition, including an amended insurance business transfer plan.

(5) Nothing in this Code section in any way affects the right of appeal of any party.

(d) An unexpired and in-force policy issued to a policyholder that resides in a state other than this state shall not be transferred and novated unless or until the assuming insurer is licensed, authorized, permitted, or otherwise legally allowed to administer the subject business in the same manner as the transferring insurer in the state of such policyholder's residence.

(e) The court may approve the requested transfer and novation of the subject business, with effectiveness of all or part of the implementation deferred until the assuming insurer is able to satisfy the requirements pursuant to subsection (d) of this Code section.

(f) The Commissioner shall promulgate rules and regulations to effectuate the provisions of this article. No insurance business transfer plan shall be approved in this state unless and until such rules and regulations are promulgated. Such rules and regulations may address, but shall not be limited to, the following issues:

(1) State insurance guaranty association coverage;

(2) The financial implications of the transaction, including solvency, capital adequacy, cash flow, reserves, asset quality, and risk-based capital;

(3) An analysis of the assuming insurer's corporate governance structure to ensure proper board management oversight and expertise to manage the subject business;

(4) The competency, experience, and integrity of the persons who would control the operations of an involved insurer; and

(5) Ensuring the transaction is not being made for improper purposes, including fraud.

(g) All testimony, documents, exhibits, analysis, communications, or other information or evidence submitted to the Commissioner or independent expert in contemplation of an application, submitted to the court in support of a petition, or developed by the Commissioner or independent expert in connection with such application or petition for an approval order and an implementation order of a plan, shall be treated for purposes of confidentiality as an examination of the financial condition or market conduct of the transacting companies as provided in Code Section 33-2-14.

History. Code 1981, § 33-52-15, enacted by Ga. L. 2024, p. 770, § 4/HB 1049, effective May 6, 2024.

33-52-16. Consent to jurisdiction.

Insurers subject to this article consent to the jurisdiction of the Commissioner with regard to ongoing oversight of operations, management, and solvency relating to the transferred business, including the authority of the Commissioner to conduct financial analysis and examinations.

History. Code 1981, § 33-52-16, enacted by Ga. L. 2024, p. 770, § 4/HB 1049, effective May 6, 2024.

33-52-17. Fees; reimbursement of expenses; penalty for nonpayment.

(a) At the time of filing its application with the Commissioner for review and approval of an insurance business transfer plan, an applicant shall pay a nonrefundable fee to the department in the amount of $10,000.00.

(b) In the Commissioner's discretion, in connection with the department's participation in the proceedings undertaken pursuant to this article, an applicant shall reimburse the department for any compen-

sation and benefits paid to the personnel of the department for time spent engaged in the proceedings, including, but not limited to, examiners, actuaries, attorneys, managers, and paraprofessionals.

(c) The Commissioner may retain independent authorized consultants, including attorneys, appraisers, actuaries, certified public accountants, or other professionals and specialists to assist department personnel in connection with the review required by this article, the cost of which shall be borne by the applicant.

(d) The applicant shall pay the expenses of the department and its authorized consultants incurred in fulfilling their obligations under this article, including the actual expenses of the department or the expenses and compensation of any consultants retained by the department.

(e) The transferring insurer and the assuming insurer shall jointly be obligated to pay any compensation, costs, and expenses of the independent expert and any consultants retained by the independent expert and approved by the department incurred in fulfilling the obligations of the independent expert under this article. Nothing in this article shall be construed to create any duty for the independent expert to any party other than the department or the court.

(f) Failure to pay any of the requisite fees or reimbursements within 30 days of demand shall be grounds for the Commissioner to request that the court dismiss the petition for approval of the insurance business transfer plan prior to the filing of an implementation order by the court, or, if after the filing of an implementation order, the Commissioner may suspend or revoke the assuming insurer's certificate of authority to transact insurance business in this state.

History. Code 1981, § 33-52-17, enacted by Ga. L. 2024, p. 770, § 4/HB 1049, effective May 6, 2024.

CHAPTER 63

GUARANTEED ASSET PROTECTION WAIVERS

Sec.
33-63-3. Definitions.

33-63-3. Definitions.

The following terms are defined for purposes of this chapter and are not intended to provide actual terms required in guaranteed asset protection waivers:

(1) "Administrator" means a person, other than an insurer or creditor, that performs administrative or operational functions pursuant to guaranteed asset protection waiver programs.

(2) "Borrower" means a debtor, retail buyer, or lessee under a finance agreement.

(3) "Creditor" means:

(A) The lender in a loan or credit transaction;

(B) The lessor in a lease transaction;

(C) Any retail installment seller that provides credit to any retail buyer of motor vehicles, provided that such entity complies with the provisions of this chapter;

(D) The seller in commercial retail installment transactions; or

(E) The assignees of any of the creditors listed in subparagraphs (A) through (D) of this paragraph to whom the credit obligation is payable.

(4) "Finance agreement" means a loan, lease, or retail installment sales contract for the purchase or lease of a motor vehicle.

(5) "Free look period" means the period of time from the effective date of the guaranteed asset protection waiver until the date the borrower may cancel the guaranteed asset protection waiver without penalty, fees, or costs to the borrower. This period of time must not be shorter than 30 days.

(6) "Guaranteed asset protection waiver" means a contractual agreement wherein a creditor agrees, with or without a separate charge, to cancel or waive all or part of amounts due on a borrower's finance agreement in the event of a total physical damage loss or unrecovered theft of the motor vehicle, which agreement must be part of, or a separate addendum to, the finance agreement or a contractual agreement wherein a creditor agrees, with or without a separate charge, to cancel or waive all or part of the excess wear and use charges owed by the borrower to the creditor under the lease contract when the borrower returns a leased vehicle to the creditor at termination of the lease, which agreement must be part of, or a separate addendum to, the lease contract. Such waiver may also provide, with or without a separate charge, a benefit that waives an amount, or provides a borrower with a credit, toward the purchase of a replacement vehicle.

(7) "Insurer" means an insurance company licensed, registered, or otherwise authorized to do business under the insurance laws of this state.

(8) "Motor vehicle" means self-propelled or towed vehicles designed for personal or commercial use, including but not limited to automobiles, trucks, motorcycles, recreational vehicles, all-terrain vehicles, campers, boats, personal watercraft, and motorcycle, boat, camper, and personal watercraft trailers.

(9) "Person" includes an individual, company, association, organization, partnership, business trust, corporation, and every form of legal entity.

(10) "Retail buyer" shall have the same meaning as provided in Code Section 10-1-31.

(11) "Retail installment seller" shall have the same meaning as provided in Code Section 10-1-31.

History.

Code 1981, § 33-63-3, enacted by Ga. L. 2008, p. 1097, § 1/SB 470; Ga. L. 2014, p. 181, § 6/HB 610; Ga. L. 2022, p. 578, § 1-2/HB 733.

Amendments.

The 2022 amendment, effective July 1, 2022, in paragraph (6), substituted "agrees, with or without a separate charge," for "agrees for a separate charge" twice in the first sentence and added the second sentence. See Editor's notes for applicability.

Editor's notes.

Ga. L. 2022, p. 578, § 3-1(b)/HB 733, not codified by the General Assembly, makes paragraph (6) applicable to all such policies and contracts issued, delivered, issued for delivery, or renewed on or after July 1, 2022.

CHAPTER 64

REGULATION AND LICENSURE OF PHARMACY BENEFITS MANAGERS

Sec.
33-64-7. Commissioner's authority over rules and regulations.

33-64-7. Commissioner's authority over rules and regulations.

(a) The Commissioner shall enforce the provisions of this chapter and may promulgate rules and regulations to implement the provisions of this chapter to ensure the safe and proper operations of pharmacy benefits managers in this state.

(b) In addition to all other authority granted by this title, the Commissioner may:

(1) Conduct financial examinations and compliance audits of pharmacy benefits managers to ensure compliance with the provisions of this chapter and rules and regulations implemented pursuant to this

chapter; provided, however, that such authority shall not extend to financial examination and compliance audits of pharmacy benefits managers' conduct in performing services on behalf of the state health benefit plan pursuant to Article 1 of Chapter 18 of Title 45 or the medical assistance program pursuant to Article 7 of Chapter 4 of Title 49. The pharmacy benefits manager subject to a financial examination or compliance audit shall pay all the actual expenses incurred in conducting the examination or audit. When the examination or audit is made by an examiner or auditor who is not a regular employee of the department, the pharmacy benefits manager examined or audited shall pay the proper expenses for the services of the examiner or auditor and his or her assistants and the actual travel and lodging expenses incurred by such examiners, auditors, and assistants in an amount approved by the Commissioner. The examiner or auditor shall file a consolidated accounting of expenses for the examination or audit with the Commissioner. No pharmacy benefits manager shall pay, and no examiner or auditor shall accept, any additional emolument on account of any examination or audit. When the examination or audit is conducted in whole or in part by regular salaried employees of the department, payment for such services and proper expenses shall be made by the pharmacy benefits manager examined or audited to the Commissioner. The Commissioner shall be authorized to keep a portion of examination or audit fees paid by the pharmacy benefits manager examined or audited to pay for any costs incurred as a result of the examination or audit, and any fees remaining shall be deposited in the state treasury; provided, however, that when a pharmacy benefits manager is examined or audited because of a complaint filed against such pharmacy benefits manager and it is determined by the Commissioner that the complaint was not justified, the expenses incurred as a result of the examination or audit shall not be assessed against the pharmacy benefits manager but shall be borne by the department;

(2) Investigate complaints of alleged violations of this chapter;

(3) Issue cease and desist orders when a pharmacy benefits manager is taking or threatening to take action in violation of this chapter or rules and regulations implemented pursuant to this chapter; and

(4) Order reimbursement to an insured, pharmacy, or dispenser who has incurred a monetary loss as a result of a violation of this chapter or rules and regulations implemented pursuant to this chapter as well as order payment of a fine not to exceed $1,000.00 per violation to an insured, pharmacy, or dispenser who has been aggrieved as a result of a violation of this chapter or rules and regulations implemented pursuant to this chapter. Such fine shall be in addition to and shall not preclude any other fines imposed

pursuant to this title. For purposes of this paragraph, a violation shall be considered to have occurred each time a prohibited act is committed.

(c) A pharmacy benefits manager shall make its records available to the Commissioner, de-identified of any protected health information, upon written demand and provide cooperation in connection with financial examinations, compliance audits, and investigations.

(d) In the event a violation of this chapter or rules and regulations implemented pursuant to this chapter is found following a complaint, the Commissioner may, at his or her discretion, conduct a compliance audit to identify whether any other similar violations have occurred within the state.

History.

Code 1981, § 33-64-7, enacted by Ga. L. 2010, p. 757, § 1/SB 310; Ga. L. 2015, p. 337, § 3/HB 470; Ga. L. 2017, p. 494, § 1/HB 276; Ga. L. 2017, p. 497, § 1/SB 103; Ga. L. 2020, p. 768, § 4/HB 946; Ga. L. 2020, p. 780, § 4/SB 313; Ga. L. 2025, p. 1029, § 33(1)/SB 153, effective July 1, 2025.

Amendments.

The 2025 amendment, effective July 1, 2025, part of an Act to revise, modernize, and correct the Code, substituted "de-identified" for "deidentified" in subsection (c).

CHAPTER 65

CORPORATE GOVERNANCE ANNUAL DISCLOSURE

Sec.
33-65-2. Definitions.

33-65-2. Definitions.

As used in this chapter, the term:

(1) "Corporate governance annual disclosure" means a confidential report filed by the insurer or insurance group made in accordance with the requirements of this chapter.

(2) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in paragraph (7) of Code Section 33-13-1.

(3) "Insurer" has the same meaning as set forth in Code Section 33-1-2, except that it shall not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(4) "Own Risk and Solvency Assessment Summary Report" means the report filed in accordance with Article 2 of Chapter 13 of this title.

History.
Code 1981, § 33-65-2, enacted by Ga. L. 2019, p. 1038, § 1/HB 367.
Code Commission notes.
Pursuant to Code Section 28-9-5, in 2022, "paragraph (7) of Code Section 33-13-1" was substituted for "paragraph (5) of Code Section 33-13-1" in paragraph (2).

CHAPTER 66

DATA ANALYSIS FOR TORT REFORM

Sec.		Sec.	
33-66-1.	(Repealed effective January 1, 2030.) Definitions.		1, 2030.) Data requests; timing; limitations.
33-66-2.	(Repealed effective January 1, 2030.) Applicability.	33-66-6.	(Repealed effective January 1, 2030.) Data analysis; initial report.
33-66-3.	(Repealed effective January 1, 2030.) Commissioner's authority.	33-66-7.	(Repealed effective January 1, 2030.) Subsequent reports.
33-66-4.	(Repealed effective January 1, 2030.) Confidentiality.	33-66-8.	(Repealed effective January 1, 2030) Repealer.
33-66-5.	(Repealed effective January		

Effective date.
This chapter became effective April 22, 2024.
Editor's notes.
Ga. L. 2024, p. 152, § 1/HB 1114, not codified by the General Assembly, provides: "This chapter shall be known and may be cited as the 'Data Analysis for Tort Reform Act.'"

33-66-1. (Repealed effective January 1, 2030.) Definitions.

As used in this chapter, the term:

(1) "Data" means any qualitative or quantitative information related to tort claims and tort claim liability collected or stored by an insurer or insurance rating organization, including but not limited to actuarial information.

(2) "Report" means the report provided for in Code Sections 33-66-6 and 33-66-7.

(3) "Tort claim" means any legal claim seeking damages for the violation of a private legal right other than mere breach of contract, whether express or implied.

(4) "Tort liability insurance" means a contract of insurance under which an insurer agrees to pay on behalf of an insured damages that the insured is obligated to pay to a third party due to a tort claim by

such third party. Such term shall include but not be limited to liability insurance as provided for in paragraph (1) of Code Section 33-7-3, malpractice insurance as provided for in paragraph (8) of Code Section 33-7-3, and vehicle insurance as provided for in Code Section 33-7-9.

(5) "Tort reform legislation" means laws enacted after July 1, 2024, designed to change the laws of the civil justice system so that tort litigation and damages are reduced and designated as such by the Commissioner.

History. Code 1981, § 33-66-1, enacted by Ga. L. 2024, p. 152, § 3/HB 1114, effective April 22, 2024.

33-66-2. (Repealed effective January 1, 2030.) Applicability.

(a) This chapter shall apply to all insurers, including but not limited to stock and mutual companies, surplus lines, nonadmitted insurers, reciprocal and interinsurance exchanges, and all licensees that under any laws of this state write or in any way provide for tort liability insurance, and to rating organizations serving such insurers.

(b) The Commissioner may request data from any insurer to which this chapter applies through the Commissioner's examination authority pursuant to Code Section 33-2-11, and in any report required under Chapter 3 of this title or any required filing under Chapter 9 of this title, or under any other authority granted to the Commissioner pursuant to this title.

(c) The Commissioner may, by rule, regulation, or order, exempt certain insurers or certain kinds of insurance from the requirements of this chapter.

History. Code 1981, § 33-66-2, enacted by Ga. L. 2024, p. 152, § 3/HB 1114, effective April 22, 2024.

33-66-3. (Repealed effective January 1, 2030.) Commissioner's authority.

(a) The Commissioner may request data from any licensed rating organization through the Commissioner's examination authority pursuant to Code Section 33-9-22.

(b) The Commissioner may consult with any state agency as the Commissioner deems necessary, and the Commissioner shall have authority to request any data from such state agency necessary to produce the reports described in Code Sections 33-66-6 and 33-66-7, unless such access is otherwise prohibited by law.

History. Code 1981, § 33-66-3, enacted by Ga. L. 2024, p. 152, § 3/HB 1114, effective April 22, 2024.

33-66-4. (Repealed effective January 1, 2030.) Confidentiality.

(a) Documents, materials, or other information in the possession or control of the department under this chapter shall be confidential by law and privileged as provided for in Code Sections 33-2-14, 33-9-14, and 33-62-3. Such documents, materials, or other information shall not be subject to disclosure under Article 4 of Chapter 18 of Title 50, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(b) Neither the Commissioner nor any person who receives confidential or privileged documents, materials, or other information while acting under the authority of the Commissioner or with whom such documents, materials, or other information are shared pursuant to this chapter shall be permitted or required to testify in any private civil action concerning any such confidential or privileged documents, materials, or other information subject to subsection (a) of this Code section.

(c) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or other information shall occur as a result of the Commissioner submitting a report as provided for in Code Section 33-6-6 or Code Section 33-66-7.

History. Code 1981, § 33-66-4, enacted by Ga. L. 2024, p. 152, § 3/HB 1114, effective April 22, 2024.

33-66-5. (Repealed effective January 1, 2030.) Data requests; timing; limitations.

(a) No later than July 1, 2024, and as often as necessary through July 1, 2029, the Commissioner shall request data from insurers, licensed rating organizations, and state agencies for the Commissioner to make findings regarding the impact of tort lawsuits and the assessment of tort related risks. The Commissioner may allow for the confidential submission of such requested data via electronic means.

(b) The data requested from insurers as provided for in subsection (a) of this Code section shall be limited to data in existence on or after January 1, 2019, and shall include but not be limited to:

(1) The number of tort lawsuits filed against the insured of an insurer;

(2) The total attorneys' fees and court costs for such tort lawsuits; and

(3) The total value of the incurred claims from any tort lawsuits.

(c) The Commissioner shall request from any relevant insurer a supplemental actuarial analysis of the risks due to tort litigation that were considered in issuing a statement of actuarial opinion either at the time of submission of the statement of actuarial opinion or within one year following such submission.

(d) The Commissioner shall request that any filings with the department made by any relevant insurer reflect the impact indicated, if any, due to the effect of the applicable provisions of any tort reform legislation enacted after July 1, 2024, in a manner prescribed by the Commissioner.

History. Code 1981, § 33-66-5, enacted by Ga. L. 2024, p. 152, § 3/HB 1114, effective April 22, 2024.

33-66-6. (Repealed effective January 1, 2030.) Data analysis; initial report.

(a) The Commissioner shall analyze the data submitted pursuant to this chapter and make certain determinations regarding the assessment of tort related risks by insurers, including but not limited to:

(1) The degree to which tort related risk is reflected in insurance premiums;

(2) The specific aspects of tort related risk that have the largest monetary impact on insurance premiums; and

(3) The potential impact of any changes to tort law on the portion of insurance premiums that reflect tort related risk.

(b) The Commissioner shall generate an initial report utilizing the items listed in subsection (a) of this Code section and any data or information necessary to support such determinations. The report may analyze any data in the Commissioner's possession, any data gathered pursuant to this chapter, and any other data submitted to the Commissioner. The Commissioner may summarize, aggregate, or otherwise make anonymous the documents, materials, or other information in the possession or control of the department so that any information or data contained in the report shall not be attributable to any specific insurer.

(c) No later than November 1, 2024, the Commissioner shall submit the initial report provided for in subsection (b) of this Code section to the Governor's office, the House Committee on Insurance, and the Senate Insurance and Labor Committee.

History.
Code 1981, § 33-66-6, enacted by Ga. L. 2024, p. 152, § 3/HB 1114, effective April 22, 2024; Ga. L. 2025, p. 1029, § 33(2)/SB 153, effective July 1, 2025.
Amendments.
The 2025 amendment, effective July 1, 2025, part of an Act to revise, modernize, and correct the Code, substituted "this Code section" for "this Code Section" in subsection (b), and substituted "Governor's office," for "Governor's Office," in subsection (c).

33-66-7. (Repealed effective January 1, 2030.) Subsequent reports.

(a) The Commissioner shall generate a subsequent report in substantially similar form to the initial report provided for in Code Section 33-66-6, and such subsequent report shall include but not be limited to:

(1) Historic and predictive trends based on submitted data;

(2) The effects of any enacted tort reform legislation; and

(3) Any further determinations or recommendations for legislative action.

(b) No later than November 1, 2029, the Commissioner shall submit the subsequent report provided for in subsection (a) of this Code section to the Governor's Office, the House Committee on Insurance, and the Senate Insurance and Labor Committee.

History.
Code 1981, § 33-66-7, enacted by Ga. L. 2024, p. 152, § 3/HB 1114, effective April 22, 2024.

33-66-8. (Repealed effective January 1, 2030) Repealer.

This chapter shall stand repealed in its entirety on January 1, 2030.

History.
Code 1981, § 33-66-8, enacted by Ga. L. 2024, p. 152, § 3/HB 1114, effective April 22, 2024.