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SpecialReport

2025 Acts Affecting Insurance

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July 21, 2025 | 2025-R-0103

Notice to Readers

This report provides summaries of new laws (public acts) significantly affecting commercial insurance enacted during the 2025 regular legislative session. OLR's other Acts Affecting reports, including Acts Affecting Housing & Real Estate and Acts Affecting Health Professionals, are, or will soon be, available on OLR's website.

Each summary indicates the public act (PA) number. Not all provisions of the acts are included. The report does not include vetoed acts unless the veto was overridden. Complete summaries of public acts are, or will soon be, available on OLR's website.

Readers are encouraged to obtain the full text of acts that interest them from the General Assembly's website or the Connecticut State Library.

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Captive Insurers

Captive Insurance Law Changes

A new law makes various changes to laws related to captive insurers (i.e. insurance companies formed to insure or reinsure the risks of its owners, parent company, or affiliated company). The law already allows several different types of captive insurers to be licensed and operate in the state. One type, a sponsored captive insurer, is generally an insurance company that insures its participants through separate participant contracts, funds its liability to each participant through protected cells, and separates each cell's assets from those of other cells and the captive insurer as a whole. The new law does the following:

1. allows other types of captive insurers domiciled in Connecticut to convert into a protected cell;

2. allows sponsored captive insurers to convey (e.g., sell, transfer, or assign) a protected cell to a new or existing sponsored captive or one licensed as a special purpose financial insurance company;

3. authorizes the insurance commissioner to separate insolvent protected cells from their sponsored captives and allows these insolvent protected cells to convert into new protected cells or captive insurers; and

4. subjects captive insurers to a fine up to $15,000 for violations (PA 25-130, effective October 1, 2025).

Health Insurance

Biomarker Testing

This session, the legislature passed a law that generally requires individual and group health insurance policies to cover biomarker testing to diagnose and treat patient diseases, such as cancer. The use of testing must be supported by medical and scientific evidence. Generally, biomarker testing identifies certain gene mutations, proteins, or other molecules that help health care providers diagnose diseases and choose targeted treatments that may help improve patient outcomes (PA 25-16, §§ 4 & 5, effective January 1, 2026).

Emergency Department Discrimination and EMTALA

A new law generally prohibits emergency departments, or health care providers providing care at them, from discriminating against a patient when providing emergency care based on various factors, including insurance status. This insurance provision is similar to an existing provision in the federal Emergency Medical Treatment and Labor Act (EMTALA). Among other related provisions, the act also specifically requires hospital emergency departments to meet the requirements of (1)

EMTALA or (2) related regulations that the Department of Public Health (DPH) must adopt under the act if EMTALA is revoked, not adequately enforced, or no longer applies (PA 25-168, §§ 171 & 172, effective upon passage).

Facility Fees

A new act reinstates a provision that makes it an unfair trade practice for a hospital, health system, or hospital-based facility to violate facility fee limits. A "facility fee" is any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate and distinct from the provider's professional fee (PA 25-94, § 10, effective January 1, 2026).

General Anesthesia Reimbursement

A new act prohibits certain individual and group health insurance policies that cover general anesthesia from (1) imposing arbitrary time limits on reimbursement for general anesthesia during a medically necessary procedure or (2) denying, reducing, terminating, or failing to provide reimbursement for general anesthesia solely because its duration exceeded the insurer's predetermined time limit for the care (PA 25-94, §§ 8 & 9, effective January 1, 2026).

Health Insurance Rate Requests Reduced

Beginning January 1, 2027, a new act allows the insurance commissioner to reduce a health carrier's individual or small employer group health insurance rate request by up to two percentage points if the carrier's average approved premium rate increase exceeded the state's health care cost growth benchmark in each of the two most recent plan years for which benchmark data is available (PA 25-94, §§ 6 & 7, effective January 1, 2027).

Health Insurance Subsidy for Early Care and Education Employees

The legislature passed a new law that requires Access Health CT (i.e. the Connecticut Health Insurance Exchange) to study the need for, and then establish, a health insurance subsidy program for FY 27 for employees of early care and education programs. The law sets certain program requirements and details a process for potential funding through the Early Childhood Education Endowment (PA 25-93, § 15, effective July 1, 2025).

In-Network Liability for Out-of-Pocket Prescription Drug Expenses

This session, the legislature passed a new law that generally requires health carriers to credit insureds or enrollees for certain prescription drug costs when determining in-network liability for

out-of-pocket expenses (e.g., coinsurance, copayment, or deductible) paid directly to a pharmacy or health care provider for prescription drugs.

The new law requires health carriers to develop a proof of payment form and publish it on their website that insureds or enrollees must provide to receive the credit for out-of-network purchases. It also limits the total amount credited toward any insured's or enrollee's annual out-of-pocket expense for prescription drugs purchased from an out-of-network health care provider. It prohibits carrying over a credit to a new policy period (PA 25-167, § 8, effective July 1, 2026).

Mandated Health Benefit Review Program

A new act eliminates a requirement that the insurance commissioner contract with the UConn Center for Public Health and Health Policy to conduct reviews of mandated health benefits upon the Insurance and Real Estate Committee's request. Instead, it allows him to contract with any actuary, actuarial firm, quality improvement clearinghouse, health policy research organization, or other independent expert necessary to help him with the reviews. By law, the reviews evaluate the social and financial impacts of the health benefits (PA 25-132, § 1, effective October 1, 2025).

Mental Health Parity Compliance

A new act (1) requires health carriers to annually file a mental health parity compliance certification with the insurance commissioner and (2) makes public a carrier's compliance with mental health parity requirements. It also authorizes the insurance commissioner to (1) impose civil penalties and late fees on carriers who fail to comply with mental health parity requirements and (2) engage certain independent experts to help with compliance reviews (PA 25-94, §§ 1-3, effective October 1, 2025).

Step Therapy Restrictions

The legislature limited a health carrier's use of step therapy under a new act. Step therapy is a prescription drug protocol that generally requires patients to try less expensive drugs before higher-cost drugs. The act prohibits certain health insurance policies or contracts from requiring the use of step therapy for drugs used to treat multiple sclerosis or rheumatoid arthritis, as long as the drug complies with approved Food and Drug Administration indications. Additionally, the act makes permanent a prohibition on the use of step therapy for drugs used to treat schizophrenia, major depressive disorder, or bipolar disorder (PA 25-94, §§ 4 & 5, effective January 1, 2026).

Wheelchair Repairs

A new act allows, rather than requires as under prior law, the insurance commissioner to adopt regulations to implement health insurance requirements for medically necessary wheelchair repairs and replacements. By law, an insurer cannot require a new prescription or prior authorization for the medically necessary repair or replacement of a complex rehabilitation technology wheelchair unless the original prescription is more than five years old (PA 25-132, §§ 3 & 4, effective upon passage).

Insurance Industry

Arbitration Procedure for Motor Vehicle Damage Claims

This session, the legislature passed a new law that makes certain private passenger motor vehicle insurers, instead of the Insurance Department, responsible for the department's administrative costs associated with statutorily required arbitration hearings to resolve disputes between claimants and insurers over claim amounts. Under the new law, if the arbitrator's decision is in the claimant's favor, the arbitrator must require the insurance company to reimburse the department for its costs to administer the arbitration hearing as long as the claimant did not reject a pre-arbitration offer of compromise from the insurance company for an amount that is at least the arbitration award's value (PA 25-131, effective October 1, 2025).

Posting and Tracking Insurance Documents

Under a new act, certain insurers may (1) electronically post insurance policy documents on their websites instead of mailing them, if certain conditions are met, and (2) send cancellation notices using the U.S. Postal Service's intelligent mail barcode tracking system (PA 25-87, §§ 1-8, various effective dates).

Public Adjuster Fees

Under a new act, (1) any fee a public adjuster charges an insured must be based only on the insurance settlement proceeds the insurer pays for a loss and (2) the adjuster must collect the fee after the insurer pays the settlement proceeds (PA 25-106, effective October 1, 2025).

Surplus Lines Brokers

A new law no longer requires brokers who seek to place or procure an insurance policy through an unaffiliated wholesale surplus lines broker to first make and document diligent efforts to obtain coverage from a licensed insurer (PA 25-87, § 15, effective October 1, 2025).

Medicaid

GLP-1 Data Collection

A new law requires the Department of Social Services (DSS) commissioner to collect data on Medicaid beneficiaries' use of glucagon-like peptide (GLP-1) drugs and related costs and benefits to the state. The commissioner must report annually, beginning by January 15, 2026, to the Appropriations, Human Services, and Public Health committees on the:

1. number of Medicaid recipients who received GLP-1 drug treatment in the last calendar year and how many recipients were prescribed this treatment for (a) type 2 diabetes or (b) cardiovascular concerns,
2. total cost to the state to provide Medicaid coverage for GLP-1 drugs, and
3. total amount of rebates or discounts the state received from pharmaceutical companies including GLP-1 drugs in the Medicaid program to the extent permissible.

The law also requires the comptroller to collect and similarly report on corresponding data, and on the number of enrollees prescribed GLP-1 drug treatment for weight loss, for state employees and retirees in the state employee health plan (PA 25-168, §§ 328 & 329, effective upon passage).

Medicaid Coverage for Breast Prostheses

A new law requires the DSS commissioner to distribute information about Medicaid coverage for a custom-made, noninvasive breast prosthesis. She must (1) include the information in a Medicaid-enrolled provider's bulletin and Medicaid enrollees' communication materials and (2) collaborate with the public health commissioner to spread the information through existing programs (PA 25-168, § 341, effective upon passage).

Obesity Treatment Prior Authorization and Step Therapy

Under federal law, states may elect to provide coverage for certain treatment for obesity under Medicaid and the Children's Health Insurance Program (CHIP). A law passed this session allows, rather than requires as under prior law, DSS to provide this coverage in Connecticut. Additionally, under the new law, if obesity treatment is provided under Medicaid and CHIP, the DSS commissioner must require prior authorization and, under certain conditions, step therapy when clinically appropriate before covering federally approved prescription drug outpatient obesity treatment for people with (1) type 2 diabetes or (2) obesity and a comorbid condition. The law limits the time step therapy can be required to up to 180 days. It also prohibits requiring step therapy for a person with a body mass index of 40 or higher if a licensed health care provider certifies in writing

that the person is scheduled to undergo surgery requiring anesthesia within the next six months (PA 25-168, § 327, effective July 1, 2025).

School-Based Health Clinic Billing

A new law requires the Transforming Children's Behavioral Health Policy and Planning Committee, in collaboration with the education and social services departments, to develop a framework and operational guidelines to streamline billing for Medicaid-eligible school-based behavioral health services. The committee must report to the Appropriations, Education, and Human Services committees on the framework and guidelines it develops by October 1, 2026 (PA 25-168, § 344, effective upon passage).

Pharmacy and Prescription Drugs

Canadian Prescription Drug Importation Program

A new law allows the Department of Consumer Protection (DCP) commissioner, after a feasibility study, to seek federal approval to establish a program to import prescription drugs from Canada for distribution in the state. It also generally does the following:

1. establishes testing, safety, quality requirements, and drug standards;
2. provides for drug tracking, tracing, recalls, embargos, and destruction;
3. establishes requirements for participating Canadian suppliers and participating wholesalers, including documentation, records retention, administrative proceedings, and penalties for violations;
4. provides for DCP emergency actions, regulations, and reporting; and
5. if the drug importation program is not feasible, allows a DCP consultant to conduct a feasibility review of Canadian prescription drug price benchmarking and develop policy recommendations (PA 25-167, §§ 9-18, effective October 1, 2027, except that the feasibility study and the definitions are effective July 1, 2025).

Health Carrier Rebate Reporting

By law, the insurance commissioner must annually report on health carrier rebate practices for the prior year and publish the report on the department's website (e.g., an explanation of how carriers accounted for rebates when calculating premiums). A new law expands the contents of this report to include (1) the percentage of rebate dollars health carriers used to reduce premiums and (2) an evaluation of rebate practices to reduce cost-sharing for health care plans delivered, issued, renewed, amended, or continued (PA 25-167, § 3, effective October 1, 2025).

Health Carrier Reporting on Pharmacy Pricing and Profit

Under a new law, the insurance commissioner must require health carriers to annually report on pricing in effect for the prior year, and profit generated between, the carrier and any pharmacy benefit manager (PBM) or mail-order pharmacy doing business in Connecticut provided it is reasonably available and the commissioner keeps proprietary information confidential (PA 25-167, § 4, effective January 1, 2026).

Identified Prescription Drugs

This session, the legislature passed a law that generally sets a (1) cap on the prices for which pharmaceutical manufacturers and wholesale distributors can sell an identified prescription drug in the state and (2) civil penalty for violators, except for those that made less than $250,000 in total annual sales in the state for the calendar year for which the penalty is being imposed. It also creates a process by which an aggrieved person can request a hearing to dispute the penalty. An "identified prescription drug" is a (1) brand name drug or biological product for which all exclusive marketing rights granted under federal patent laws and other federal laws have expired for at least 24 months, including any drug-device combination product to deliver a brand-name drug or biological product or (2) generic drug or interchangeable biological product (PA 25-168, §§ 345-347, effective July 1, 2025).

Pharmacists' Compensation Study

The legislature passed a new law requiring the Insurance and Real Estate Committee chairpersons, or their designees, to convene a working group to study and make legislative recommendations on the compensation of licensed pharmacists who perform certain health services (e.g., administer vaccines, HIV-related tests, and influenza-related tests and prescribe contraceptive devices or products). The working group must report its findings and legislative recommendations to the Insurance and Real Estate Committee by February 1, 2026 (PA 25-167, § 7, effective upon passage).

Pharmacy Benefit Manager Drug Pricing for Health Plans

A new public act requires a PBM to offer a health plan the option of being charged the same price for a prescription drug that the PBM pays a pharmacy for the drug.

Under existing law and the act, the following apply:

1. any contract provision that violates the act is void and unenforceable, but a provision rendered invalid or unenforceable does not affect remaining provisions;

2. any general business practice that violates the act's provisions is an unfair trade practice under the Connecticut Unfair Trade Practices Act; and

3. the insurance commissioner may enforce the act's provisions and, upon request, audit pharmacy services contracts for compliance (PA 25-167, § 2, January 1, 2026).

Pharmacy Benefit Manager Duty of Good Faith and Fair Dealing

A new law requires PBMs to exercise good faith and fair dealing in performing their contractual duties to health carriers or other health benefit plan sponsors. It also specifies that a PBM has an obligation of good faith and fair dealing in performing its duties with all parties, including carriers and other plan sponsors. Under the new law, a PBM must notify the health carrier or plan sponsor, in writing, if any of the PBM's activities, policies, or practices directly or indirectly present a conflict of interest with these duties. It also authorizes the insurance commissioner to adopt implementing regulations (PA 25-167, § 1, effective October 1, 2025).

Prescription Drug Rebate Reports

The legislature delayed the annual due date for PBMs to report prescription drug rebate information to the insurance commissioner by one month, from February 1 to March 1. It correspondingly delayed the annual due date for the commissioner to report to the Insurance and Real Estate Committee on the PBMs' rebate reports, from March 1 to April 1 (PA 25-132, § 2, effective upon passage).

Prescription Drug Shortages Task Force

A new law creates an ongoing task force to study emergency preparedness and mitigation strategies for prescription drug shortages. The task force must identify drugs at risk of shortage in this state and recommend ways to address that.

Starting by January 1, 2026, the task force must annually report its findings and recommendations to the General Law, Human Services, Insurance and Real Estate, and Public Health committees. The reports must identify (1) the drugs the task force determines are at risk of shortage and (2) strategies to mitigate these shortages, including ways to increase in-state production of drugs that are at risk of shortage and critically necessary to provide health care in the state (PA 25-167, § 5, effective upon passage).

Property and Casualty Insurance

Flex Rating Personal Risk Insurance

A new act extends the sunset date for the personal risk insurance (e.g., home, auto, marine, or umbrella) "flex rating" law from July 1, 2025, to July 1, 2030. The flex rating law allows property and casualty insurers to file new personal risk insurance rates with the insurance commissioner and begin using them immediately, without prior approval, under certain circumstances (PA 25-86, effective June 30, 2025).

Flood Insurance Disclosure Required

This year, the legislature passed a law requiring insurers to include a clear, conspicuous, and plain language notice in each homeowners and renters insurance policy stating that (1) losses caused by a flood are not covered under the policy and (2) flood insurance is available for purchase under a separate flood insurance policy (PA 25-33, § 1, effective July 1, 2026).

Workers' Compensation

Compensation to Injured Employees and Parents of a Deceased Employee and Other Changes to the Workers' Compensation Act

In response to a recent state Supreme Court decision, the General Assembly passed legislation removing an administrative law judge's discretion to award temporary partial incapacity benefits instead of permanent, partial disability (PPD) benefits, once an injured employee reaches maximum medical improvement.

The new law also (1) increases the duration of certain PPD benefits and expands the list of injuries eligible for PPD benefits; (2) allows a deceased employee's parents, when there are no dependents for distribution of workers' compensation benefits, to each receive an equal portion of the benefits; (3) creates a working group to study certain workers' compensation issues; and (4) allows injured workers to receive up to 60 weeks of supplemental benefits under certain limited circumstances (PA 25-12, §§ 13-16, effective upon passage).

Workers' Compensation Fee Schedule

Existing law generally requires the Workers' Compensation Commission's chairperson to annually (1) set a fee schedule for workers' compensation medical providers who provide medical services under the Workers' Compensation Act and (2) update relative values based on the Medicare resource-based relative value scale (RBRVS), which ranks medical services by the relative cost of resources needed to produce them.

By law, the chairperson was required to convert to a fee schedule using the RBRVS as the basis for workers' compensation practitioner fees in 2008, and the conversion had to be revenue neutral. This act removes the requirement that the conversion be revenue neutral, clarifying it does not apply to the annual RBRVS-based fee schedule updates (PA 25-50, effective July 1, 2025).

Miscellaneous

"Accidental Failure to File" Statute

The state's "accidental failure of suit" law generally authorizes a new lawsuit to be filed within one year after a case was dismissed because of certain reasons unrelated to the merits, even though the statute of limitations has expired (the original case must have been commenced within the statute of limitations).

Under new legislation, for purposes of this law, a defendant's receipt of the summons and complaint in the underlying case is a sufficient way to constitute the case's commencement, among other ways. It specifically applies not just to receipt by defendants but also by their agents or representatives, including the defendant's purported insurer allegedly obligated to defend the case. The act specifies that its provisions do not (1) obligate the insurer to serve any complaint or other legal action on the purported insured or (2) affect whether the served insurer owes a duty to defend or to provide indemnity coverage to the purported insured (PA 25-118, effective October 1, 2025).

AHEAD Federal Demonstration Model

A new law requires the DSS commissioner, within available appropriations, to develop a methodology and implementation plan for financing structures or alternative payment methodologies for hospitals under the Advancing All-Payer Health Equity Approaches and Development (AHEAD) federal demonstration program administered by the federal Centers for Medicare and Medicaid Services (CMS).

Under the act, the commissioner must report by January 31, 2026, to the Appropriations, Human Services, and Public Health committees on the implementation plan and methodologies. At least 30 days after doing so, she may apply to CMS for a Medicaid waiver to implement the methodologies she develops. Hospitals are not required to participate in the AHEAD program and cannot be made to do so as a condition of Medicaid reimbursement or certificate of need approval.

AHEAD is an 11-year federal demonstration program (from 2024 to 2034) administered by CMS. The program is a state total cost of care model under which Connecticut will assume responsibility

for managing health care quality and costs across all payors (Medicaid, Medicare, and private insurers) (PA 25-168, § 47, effective October 1, 2025).

Bail Enforcement

A new law prohibits bail bondsmen and surety bail bond or bail enforcement agents from taking or trying to take the principal on a bond into custody on the premises, grounds, or campus of certain health care facilities or offices, schools, higher education institutions, and houses of worship. It also expands the scope of the law requiring the court to vacate an order forfeiting a bond and release the bondsman, agent, and insurer, to apply when the principal on the bond is at these health care facilities or offices (PA 25-25, effective October 1, 2025).

Fallen Hero Fund

A new law expands the availability of the "Fallen Officer Fund" to include additional first responders, including firefighters, emergency medical technicians, and paramedics. It correspondingly renames it the "Fallen Hero Fund," which gives a lump sum death benefit totaling $100,000 to a surviving family member or beneficiary of a first responder killed in the line of duty or who sustained injuries that were the direct or proximate cause of the first responder's death, within available appropriations. Additionally, the law allows certain survivors to apply for or keep health care coverage for one year after a first responder's death and renew the coverage annually for up to five years (PA 25-61, effective July 1, 2025).

Federal Home Loan Banks and the Insurers Rehabilitation and Liquidation Act

A new act amends the Insurers Rehabilitation and Liquidation Act to allow certain activities to proceed when a Federal Home Loan (FHL) Bank is a party to an agreement with an insurer that is under conservation, rehabilitation, liquidation, or administrative supervision by the Connecticut Insurance Department. Among other things, the act (1) eliminates, for up to 10 business days, the automatic stay that an application or petition for a delinquency proceeding, rehabilitation, or liquidation order typically grants when an FHL Bank is a party; (2) requires, to the extent agreements to which an FHL Bank is a party have preferences to creditors, an insurer's liquidator to carry a preference out; and (3) sets requirements for how an FHL Bank may exercise collateral rights (PA 25-87, §§ 9-13, effective October 1, 2025).

Hospital Reporting on Emergency Departments

Existing law generally requires hospitals to annually analyze certain emergency department data toward the goals of (1) developing ways to reduce admission wait times, (2) informing potential

ways to improve admission efficiencies, and (3) examining root causes for admission delays. By each March 1 (until 2029), they must annually report to the Public Health Committee on their findings and recommendations. A new law requires them to also submit these reports to the DPH and Office of Health Strategy commissioners and the Healthcare Advocate (PA 25-168, § 189, effective upon passage).

Payment for Certain Pretrial Programs

A new law requires a person's health insurance (specifically private, Medicaid, or Medicare), rather than the Department of Mental Health and Addiction Services (DMHAS), to cover the costs of substance use treatment under the pretrial Drug Intervention and Community Service Program or pretrial Impaired Driving Intervention Program if (1) the court finds the person is indigent and unable to pay, (2) the court waives the costs, and (3) these costs are a covered benefit under the person's insurance. DMHAS must continue to pay other program-related treatment costs not covered by insurance (PA 25-168, §§ 113 & 114, effective July 1, 2025).

Personal Liability Insurance for State Marshals

Among other things, a new law increases the amount of personal liability insurance each state marshal must carry for damages caused by their tortious acts (i.e. certain negligent acts, errors, or omissions) as follows:

1. from $100,000 to $250,000, for damages caused to any one person or any one person's property and
2. from $300,000 to $500,000, for damages caused to more than one person or more than one person's property.

Starting January 1, 2026, the new law also requires renewed personal liability insurance policies to have annual coverage that extends from October 1 to September 30 (PA 25-78, § 1, effective October 1, 2025).

Tort Claims Against Estates in Superior Court

Under existing law, anyone who has brought a claim against a decedent's estate cannot sue on that claim unless the estate's fiduciary has rejected it. Generally, the person must bring the lawsuit within 120 days after the claim's rejection.

A new law overrides these provisions and prohibits tort claims against an estate in Superior Court from being dismissed for lack of subject matter jurisdiction, to the extent the claim is within existing insurance coverage. The act specifies that it does not allow for recovery (1) beyond the tort's

insurance limits or (2) from the fiduciary, the decedent's estate, or any estate creditor or beneficiary. The recovery is limited to the insurance policy in effect when the tort occurred unless the creditor otherwise complied with existing law's requirements (PA 25-48, § 8, effective October 1, 2025).

Volunteer Physicians' Malpractice Insurance Exception

A new law exempts physicians from having to maintain malpractice insurance when providing volunteer behavioral health services at a nonprofit clinic that provides free services and maintains its own insurance in specified amounts (PA 25-96, § 14, effective October 1, 2025).

Withholding for Certain Retirement Income Distributions

A new law suspends the income tax withholding requirement on lump sum distributions from pensions, annuities, and other specified sources from July 1, 2025, through December 31, 2026. But it requires payers (e.g., retirement plan servicers) to withhold taxes from these distributions if the payee has requested it.

By law, a "lump sum distribution" is a payment greater than $5,000 or more than 50% of the payee's entire account balance, whichever is less, subject to certain exclusions. As of January 1, 2025, income tax withholding is required for other (non-lump sum) distributions from pensions, annuities, and other specified sources only if the payee requests it (PA 25-168, § 401, effective July 1, 2025).

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