COUNCIL OF THE DISTRICT OF COLUMBIA
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1350 PENNSYLVANIA AVENUE, NW
WASHINGTON, D.C. 20004

CHRISTINA HENDERSON
Councilmember, At-Large
Chairperson, Committee on Health

Committee Member
Human Services
Facilities
Transportation and the Environment

Statement of Introduction
Medical Debt Mitigation Amendment Act of 2025
October 20, 2025

Today, I am pleased to introduce the Medical Debt Mitigation Amendment Act of 2025, along with Councilmembers Charles Allen, Anita Bonds, Janeese Lewis George, Brianne Nadeau, Zachary Parker, Brooke Pinto, and Robert White. This legislation would prevent and mitigate the burden of unpaid medical bills on District families, while increasing transparency in medical billing and ensuring fair debt collection.

Tzedek DC's June 2025 report *More than a Band-Aid-Systemic Changes to Protect DC Residents from Medical Debt,*[1] finds that nearly 90,000 District residents (20% of all residents) have unpaid medical bills. Research shows medical debt can have significant negative impacts on a household, including bankruptcy, job loss, eviction, food insecurity, and poor physical and mental health outcomes.[2]

Although medical debt is often treated similar to other types of consumer debt, like credit card debt, research from the Consumer Financial Protection Bureau has found that "medical debt on a credit report is less predictive of future defaults or serious delinquencies than the presence of non-medical collections tradeline."[3] This is because the majority of medical debt comes from an acute illness or medical procedure, not reflective of a person's voluntary spending habits.

In 2024, the District government, through a Department of Health Care Finance grant, cancelled $42 million of medical debt for over 62,000 residents. The program funded the purchase of debt portfolios at discounted rates directly from hospital systems via the nonprofit Undue Medical Debt. However, this program was retroactive and did not address the causes of medical debt, so many of the residents whose debt was forgiven could have since accrued more medical debt. Research has since shown that the retroactive, one-time forgiveness of medical debt is not

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[1] Tzedek DC, "Press Release: Tzedek DC Releases Groundbreaking Report on DC's Medical Debt Crisis, Urges Action as Medicaid Protections Face Threats" (June 10, 2025), https://www.tzedekdc.org/news-1/2025/6/9/tzedek-dc-releases-groundbreaking-report-on-dcs-medical-debt-crisis-urges-action-as-medicaid-protections-face-threats.
[2] *Id.;* Rakshit, S., Rae, M., Claxton, G., Amin, K., Cox, C., The Burden of Medical Debt in the United States, Peterson Center on Healthcare and Kaiser Family Foundation (Feb. 14. 2024), https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/.
[3] 12 CFR Part 1022 Final Rule: Prohibition on Creditors and Consumer Reporting Agencies Concerning Medical Information (Regulation V), Consumer Financial Protection Bureau (Jan. 7, 2025), https://www.consumerfinance.gov/rules-policy/final-rules/prohibition-on-creditors-and-consumer-reporting-agencies-concerning-medical-information-regulation-v/.

effective for preventing future medical debt or improving physical or mental health outcomes.[4] It is therefore imperative that the District take a more upstream approach to preventing and mitigating medical debt. This bill is particularly timely given current and upcoming local and federal changes to public health insurance programs, which will limit eligibility and benefits and likely lead to more District residents being uninsured or underinsured.

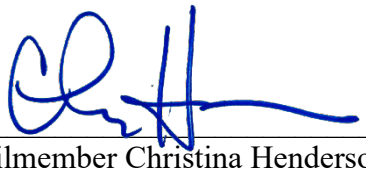
Specifically, this legislation would:

- **Strengthen large health care facilities' financial assistance policies (FAPs),** which provide free and reduced care to low-income patients, by establishing uniform income eligibility criteria and required documentation to prove income, requiring transparent publication and communication of financial assistance policies to patients, and requiring facilities to provide good faith estimates about the cost of health care services to patients before treatment, except in emergency circumstances;
- **Create protections to mitigate the burden of medical debt** by requiring facilities to offer payment plans to low-income patients with unpaid medical bills, prohibiting the reporting of medical debt to credit reporting agencies, regulating the promotion of medical lending products, and capping out of pocket charges at a percentage of insurance rates;
- **Update medical debt collection practices** by prohibiting wage garnishments and home liens for medical debt, prohibiting lawsuits against patients eligible for free and discounted care under the financial assistance policy, prohibiting collections actions during insurance appeals, and updating the District's hospital lien law and debt collectors' ability to revive a medical debt judgment; and
- **Establish legal enforcement and oversight** by granting enforcement power to DC Health and the Office of the Attorney General for violations of this Act.

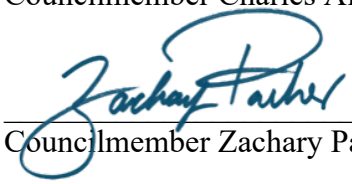
I look forward to working with my Council colleagues to move this legislation forward and support District residents and their families who incur high health care costs and debt while receiving medical care.

[4] Kluender, R., Mahoney, N., Wong, F., Yin, W., The Effects of Medical Debt Relief: Evidence from Two Randomized Experiments, National Bureau of Economic Research (Nov. 2024), https://www.nber.org/papers/w32315.

Councilmember Charles Allen



Councilmember Christina Henderson



Councilmember Zachary Parker

Councilmember Anita Bonds

Councilmember Brianne K. Nadeau

Councilmember Robert C. White, Jr.

Councilmember Brooke Pinto

Councilmember Janeese Lewis George

A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To amend the Health Services Planning Program Re-establishment Act of 1996 to require the Department of Health to collect certain data, to require medical creditors to offer payment plans to eligible patients, to prohibit the reporting of medical debt to a credit reporting agency, to prohibit a large health care facility or employee from assisting a patient with or promoting medical lending products, to prohibit a large health care facility or employee from requiring a credit card authorization before providing necessary health services, to prohibit wage garnishments and property liens to collect on a medical debt, and to grant enforcement powers to the Office of the Attorney General; to amend Chapter 2 of Title 40 of the District of Columbia Official Code to limit liens for emergency health services provided by a large health care facility to the lesser of the amount the patient owes after insurance claims or 33% of the total amount awarded to the patient; and to amend Chapter 1 of Title 15 of the District of Columbia Official Code to prevent the revival of judgments against a debtor for medical debt.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Medical Debt Mitigation Amendment Act of 2025".

Sec. 2. The Health Services Planning Program Re-establishment Act of 1996, effective April 9, 1997 (D.C. Law 11-191; D.C. Official Code § 44-401 *et seq.*), is amended as follows:

(a) Section 2 (D.C. Official Code § 44-401) is amended as follows:

(1) A new paragraph (3C) is added to read as follows:

"(3C) "Consumer reporting agency" shall have the same meaning as provided in section 603(f) of the Fair Credit Reporting Act, approved October 26, 1970 (84 Stat. 1128; 15 U.S.C. §1681a(f)).".

(2) New paragraphs (9C) and (9D) are added to read as follows:

"(9C) "External review" means a review of an adverse benefit determination as defined in section 101(1) of the Health Benefits Plan Members Bill of Rights Act of 1998, effective April 27, 1999 (D.C. Law 19-229; D.C. Official Code § 44-301.01(1)).

"(9D) "Financial assistance policy" means a written policy created by a large health care facility, which shall include:

"(A) Eligibility criteria for financial assistance for health services, including free or discounted care;

"(B) The basis for calculating amounts charged to patients;

"(C) The method and application process for patients to apply for financial assistance;

"(D) The information and documentation the large health care facility requires an individual to provide as part of the application;

"(E) The steps that the provider will take to determine whether a patient is eligible for financial assistance, including the maximum amount of days for the facility to provide a determination;

"(F) The process for a patient to dispute an adverse financial assistance decision;

"(G) The billing and collections policy, including the actions a large health care facility may take in the event of non-payment; and

"(H) The large health care facility's methods to ensure patients have access to and understanding of the financial assistance policy.".

(3) A new paragraph (13A) is added to read as follows:

"(13A) "Large health care facility" means a private general hospital, psychiatric hospital, specialty hospital, outpatient clinic or facility operating under the license of a hospital or of which a majority of its ownership is by a hospital, or freestanding emergency department.".

(4) New paragraphs (14B), (14C), and (14D) are added to read as follows:

"(14B) "Medical debt collector" means an entity that regularly collects or attempts to collect, directly or indirectly, medical debts originally owed or due, or asserted to be owed or due, to a large health care facility, including large health care facilities to whom a patient owes money for health care services, a collection agency or debt buyer who has purchased the medical debt that a patient owed a large health care facility, or any other entity considered a debt collector as defined by D.C. Official Code § 28–3814(b)(5).

"(14C) "Medical debt" means a debt arising from the receipt of health care services, products, or devices.

"(14D) "Medical lending products" means medical credit cards or third-party medical installment loans issued specifically for the payment of health services, products, or devices provided to a person.".

(5) A new paragraph (16A) is added to read as follows:

"(16A) "Patient" means a person who received health care services, and shall include a parent or legal guardian if the patient is a minor, legal guardian if the patient is an adult under guardianship, or legally appointed healthcare agent for the patient.

(b) New sections 6a, 6b, 6c, 6d, and 6e are added to read as follows:

"Sec. 6a. Financial assistance policy requirements and eligibility.

"(a) A large health care facility shall establish a financial assistance policy to provide financial assistance to eligible patients, regardless of residency, health insurance coverage status, citizenship or immigration status, assets, or prospective assets.

"(b) A large health care facility shall make its financial assistance policy, including a user-friendly summary, publicly available, and:

"(1) Provide written notification to patients in their preferred language during the intake and registration process, and during discharge;

"(2) Clearly communicate through notices posted in high traffic areas of the large health care facility, and on bills and statements sent to patients, that financial assistance is available to eligible patients and instructions to apply for assistance; and

"(3) Include in its financial assistance application materials a notice to patients that, upon submission of a completed financial assistance application, the patient does not need to pay the medical bill until the large health care facility has rendered a decision on the application.

"(c) A large health care facility shall screen patients for eligibility for financial assistance according to the following process:

"(1) Determine whether the patient has health insurance and:

"(A) If the patient is uninsured, inform the patient of a good faith estimate of the cost of the health services before the provision of health services, except in emergency or life threatening situations; or

"(B) If the patient is insured, inform the patient of a good faith estimate of the cost-sharing responsibilities under the patient's health insurance plan or the cost of the service if not covered by the insurance plan before the provision of health services, except in emergency or life threatening situations;

"(2) Offer to screen the patient for eligibility for financial assistance; and

"(3) If the patient submits an application for financial assistance, determine the patient's eligibility for the financial assistance plan within 14 days after the patient applies for financial assistance and suspend any billing or collections actions while the patient's eligibility is being determined.

"(d) A patient's refusal to be screened for financial assistance shall not be grounds for not providing health services or denying financial assistance in the future if the patient later decides to apply.

"(e) The following patients shall qualify for financial assistance under a large health care facility's financial assistance policy:

"(1) Patients with household income of 200% or less of the federal poverty level shall receive free care;

"(2) Patients with household income of 201-400% of the federal poverty level shall be charged no more than 25% of a recalculated amount of the costs billed to the patient for a specific health service using the Medicare reimbursement rate applied on the date of service;

"(3) In addition to other financial assistance provided under this act, no patient with household income at or below 400% of federal poverty level shall be required to pay more than $2,300 in cumulative medical bills to a single large health care facility per calendar year, adjusted for inflation annually by the Department of Health ("Department") through rulemaking.

"(f) Nothing in this section shall be construed to limit the ability of a large health care facility to establish patient eligibility for financial assistance at income levels higher than those specified herein or to provide greater financial assistance for eligible patients than those required by this section.

"(g)(1) The following criteria shall be used to determine a patient's income eligibility for financial assistance by a large health care facility:

"(A) Most recent available tax return; provided that, the facility may not use information regarding medical expense deductibles in the tax return to reduce financial assistance otherwise available;

"(B) Recent pay stubs from all adults in the patient's household;

"(C) Documentation showing the patient is enrolled in a public benefits program established by the District or federal government; or

"(D) Other documentation of household income which the Mayor has identified through rulemaking.

"(2) Additional documentation other than proof of income shall not be required.

"(3) A large health care facility may grant financial assistance notwithstanding a patient's failure to provide one of the required forms of documentation described in paragraph (1) of this subsection.

"(4) A large health care facility shall inform any patient who is deemed eligible for financial assistance that the large health care facility has reduced or eliminated their medical bill, specify if any amount is currently outstanding, and explain how to apply for additional financial assistance for any remaining balance.

"(5) If a large health care facility uses credit reports or scores or similar screening tools when determining eligibility for financial assistance, the large health care facility shall:

"(A) Use these tools only to make a positive eligibility determination and still permit patients to submit applications for financial assistance without use of those tools; and

"(B) Obtain patient consent for a credit report or score check through a signed individual standalone document granting permission for such a check. Any such permission shall be effective for no more than 30 days.

"(h) Beginning one year after the effective date of this section, and annually thereafter, each large health care facility shall report to the Department:

"(1) The number of patients who received financial assistance in the past 12 months, disaggregated by free or discounted care, residency, race, ethnicity, age, and primary-language-spoken;

"(2) The total amount of financial assistance provided by the large health care facility, broken down by free and discounted care;

"(3) The total number and dollar amount of outstanding medical bills owed by patients to the large health care facility, including a list of the specific medical bill amounts per patient, and the percentage of these patients that have been screened for financial assistance eligibility;

"(4) A description of how the large health care facility is publicizing its financial assistance policy and communicating to patients about eligibility; and

"(5) Any other information regarding medical debt required by the Department through rulemaking.

"(i) No later than 6 months after the effective date of this section, the Department shall promulgate rules that include:

"(1) The process for a large health care facility to screen a patient for financial assistance eligibility;

"(2) The process for a large health care facility to document that a patient has made an informed decision to decline financial assistance screening;

"(3) The process for a large health care facility to:

"(A) Initiate a screening after a patient receives health services; and

"(B) Request information from the patient needed for the screening process;

"(4) The requirements for notifying the patient of the results of a financial assistance screening, including an explanation of the basis for a denial of financial assistance and the process for appealing a denial if necessary;

"(5) Guidelines for patient appeals regarding eligibility for financial assistance;

"(6) Steps a large health care facility shall take before sending medical debt to collections; and

"(7) The process for patients to submit a complaint relating to noncompliance with this section to the Department by phone, mail, or online, which the Department shall review within 30 days after receiving a complaint.

"(j) The Department shall periodically review large health care facilities' compliance with this section. If the Department finds that a large health care facility is not in compliance with this section, the Department shall notify the large health care facility and the facility shall have 90 days to file a corrective action plan; provided, that a large health care facility may request up to 120 days to submit a corrective action plan.

"(k) If a large health care facility's noncompliance with this section is determined by the Department to be knowing or willful or there is a repeated pattern of noncompliance, the Department of Health may fine the facility up to $10,000 per week of noncompliance, adjusted annually for inflation by the Department through rulemaking. If the large health care facility fails to take corrective action or fails to file a corrective action plan pursuant to subsection (j) of this section, the Department of Health may fine the large health care facility up to $10,000 dollars per week of noncompliance, adjusted annually for inflation by the Department through rulemaking, until the large health care facility takes corrective action. The Department of Health shall consider the size of the large health care facility and the seriousness of the violation in setting the fine amount.

"(l) The Department shall make the information reported pursuant to subsection (h) of this section and any corrective action plans for which fines were imposed on a large health care facility pursuant to subsection (j) of this section available to the public.

"(m) The Department shall share information obtained pursuant to subsections (h), (j), and (k) of this section with the Office of the Attorney General, upon request, within 30 days of the request.

"Sec. 6b. Medical debt payment plans.

"(a) For a patient with a household income at or below 400% of the federal poverty level, a large health care facility shall:

"(1)(A) Offer a payment plan of at least 36 months, with monthly installment payments not to exceed 3% of the patient's monthly household income. After a patient has made 36 payments, the remaining total amount, including amounts owed for services, fees, and facility uses, owed to the large health care facility shall be forgiven or voided. The unpaid amount remaining after 36 payments may be counted towards a large health care facility's uncompensated care requirement.

"(B) Any medical debt sold by a large health care facility to another medical debt collector shall keep the terms of the payment plan entered into by the patient and large health care facility.

"(C) The patient's initial payment on the payment plan is not due until at least 90 days after being discharged or treated by the large health care facility.

"(D) Upon written request by the patient, the medical debt collector may provide a payment plan of less than 36 months and/or a payment plan with a higher monthly cost than required by this section; and

"(2) Impose no additional interest or late fees to a patient's debt, unless that patient has refused financial assistance or has violated the terms of their payment plan.

"(b) A large health care facility shall provide in writing to each eligible patient who incurs expenses related to health care services information about the availability of a payment plan for the debt. This information shall be discussed and disclosed to the patient prior to the patient being discharged. Patients shall receive an itemized hospital bill for provided services, and a written document explaining the existence of a payment plan option, eligibility for a

payment plan, and how to request a payment plan with the large health care facility. The patient shall have 30 days after being discharged to decide whether to enter a payment plan.

"(c) Any large health care facility that enters a payment plan with a patient for expenses related to health care services shall provide the consumer with a written copy, via mail or email, of the payment plan within 7 calendar days of the agreement being made.

"(d) The written payment plan shall include, at a minimum:

"(1) The total amount of the debt owed, including principal, fees, and any other charges;

"(2) The schedule of installment payments, including the date by which the account will be paid in full if payments set by the schedule in the payment plan are made without interruption; and

"(3) Disclosure regarding whether late or missed payments will incur penalties to the debt.

"(e) A medical debt collector may accelerate a payment plan or declare it in default or no longer operative due to nonpayment only after:

"(1) The patient fails to make scheduled payments on the payment plan for at least 3 consecutive months;

"(2) The medical debt collector has made at least 3 reasonable attempts to contact the patient by telephone or other method preferred by the patient;

"(3) The medical debt collector has provided the patient written notice that the payment plan may become inoperative and that the patient may renegotiate the payment plan; and

"(4) The medical debt collector has made a good faith effort to renegotiate the terms of the payment plan, if requested by the patient.

"(f) For purposes of this section, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient.

"(g) The medical debt collector shall not commence a civil action against the patient for nonpayment until at least 90 days after the payment plan is declared to be no longer operative.

"Sec. 6c. Protections to mitigate impact of medical debt.

"(a) A medical debt collector shall not report to a consumer reporting agency the amount or existence of any medical debt that a patient owes.

"(1) A violation of this subsection shall be considered an unlawful debt collection practice under D.C. Official Code § 28-3814.

"(b) A large health care facility shall include a provision in any contract entered into with a debt collector, as defined in D.C. Code § 28-3814(a)(5), for the purchase or collection of medical debt that prohibits the reporting of any portion of such medical debt to a consumer reporting agency.

"(c) Subsections (a) and (b) of this section shall be construed to limit a consumer reporting agency from reporting known debts.

"(d) A large health care facility or an employee or agent of a large health care facility shall not:

"(1) Complete, or assist a patient in completing, any portion of an application for a medical lending product;

"(2) Promote a medical lending product with deferred interest;

"(3) Charge a medical lending product for a medical procedure not yet conducted;

"(4) Offer a patient a medical lending product or charge another form of credit when the patient's insurance, including Medicaid, will cover the services, unless the amount is for a copay, deductible, or co-insurance;

"(5) Offer a medical lending product or charge another form of credit for an eligible patient until the large health care facility has offered or conducted a financial assistance eligibility screening pursuant to section 4(c) of this Act; or

"(6) Require credit card pre-authorization or require the patient to have a credit card on file prior to administering emergency health services.

"Sec. 6d. Medical debt collection protections.

"(a) Beginning one year after the effective date of this section, a medical debt collector shall not engage in debt collection until 180 days after the date the patient receives the first posted medical bill. The posting of the first medical bill shall not be deemed debt collection for purposes of this section.

"(b) Beginning one year after the effective date of this legislation, a medical debt collector shall provide at least 90 days' notice to the patient before commencing debt collection and shall include with the notice a statement that explains the availability of free or discounted care for qualified individuals and how to apply for financial assistance.

"(c) A medical debt collector may not file a lawsuit or engage in medical debt collection against a patient who is eligible for free or discounted care under the large health care facility's financial assistance policy, unless that patient has refused financial assistance or has defaulted on their payment plan.

"(e) For patients who do not qualify for financial assistance, a medical debt collector shall not charge interest on medical debt to exceed 3% annually.

"(f)(1) A large health care facility shall consider a patient's application for financial assistance for up to one year from the date of the first posted medical bill; provided, that, if a patient is the subject of a collection activity by the facility or another medical debt collector, and submits an application for financial assistance, the large health care facility shall consider the application at any time. When an application for financial assistance is submitted, the medical debt collector shall cease collection activity and wait for notification from the large health care facility regarding the status of the debt, including new payment plan terms or debt cancellation.

"(2) DC Health shall determine through rulemaking reasonable limitations on the submission of multiple financial assistance applications used to avoid debt collection.

"(g) If a medical debt collector collects on a medical debt or initiates collection activities and it is later determined that the patient was not screened for financial assistance eligibility pursuant to section 6a(c) and is determined to qualify for financial assistance, the medical debt collector shall:

"(1) if the court has entered a judgment on the medical debt:

"(A) Request the court to vacate the judgment in any collection lawsuit over the medical debt and attempt to enter into a payment plan with the patient;

"(B) Request the court reduce the amount of the judgment, including any fees and costs related to the collection lawsuit, to the total amount the patient owes pursuant to the financial assistance policy that the patient qualifies for, attempt to enter into a payment plan with the patient, and suspend all execution on the judgment while the patient is compliant with the terms of the payment plan;

"(C) File a partial satisfaction of judgment such that the remaining unpaid balance of the judgment, including any fees and costs related to the collection lawsuit, is equal to

the total amount the patient owes under the financial assistance policy that the patient qualifies for, attempt to enter into a payment plan with the patient, and suspend all execution on the judgment while the patient is compliant with the terms of the payment plan; or

"(D) File a satisfaction of judgment and refund any excess amount to the patient if the patient has paid any part of the medical debt in excess of the amount that the patient owes after being screened for financial assistance eligibility.

"(2) For the purposes of paragraphs (1)(B) and (1)(C) of this subsection, the large health care facility shall indemnify the medical debt collector with whom they have contracted for any fees and costs awarded as part of the judgment in connection with the medical debt.

"(3) A medical debt collector that knows or should have known about an internal review, external review, or other appeal of a health insurance decision that is pending or was pending within the previous 90 days that forms the basis of the medical debt shall not:

"(A) Communicate with the patient regarding the unpaid charges for health services for the purpose of seeking to collect the charges;

"(B) Initiate a lawsuit or arbitration proceeding against the patient relating to the medical debt or unpaid charges for health services; or

"(C) Refer, sell, or send the medical debt to another medical debt collector.

"(h) For the purposes of this section, a review or appeal of a health insurance decision includes:

"(1) An appeal or grievance filed with an insurer for a review of a decision to deny, reduce, limit, terminate, or delay covered health services;

"(2) An independent medical review by the large health care facility providing medical services;

"(3) An appeal regarding Medicare coverage consistent with federal law and regulations; or

"(4) An appeal or request for an external review.

"(i) A medical debt collector shall not:

"(1) Enforce a property lien against a patient's primary residence, or

"(2) Garnish the wages of a patient with an annual household income less than 400% of the federal poverty level.

"(j) A violation of this section shall be considered an unlawful debt collection practice under D.C. Official Code § 28-3814.

Sec. 3. Section 1 of An Act To establish a lien for moneys due hospitals for services rendered in cases caused by negligence or fault of others and providing for the recording and enforcing of such liens, approved June 30, 1939 (53 Stat. 990; D.C. Official Code § 40-201)), is amended as follows:

(a) Designate the existing text as subsection (a).

(b) New subsections (b) and (c) are added to read as follows:

"(b) A lien established for a medical service to a patient who has health insurance and is injured by reason of an accident shall be limited to the amount of the individual's responsibility under the insurance policy if the insurance claim is paid or to the amount of the insurance policy's negotiated rate for services if the claim is not paid.

"(c) The total amount of all liens under this act shall not exceed 33% of the amount of a verdict, judgment, award, settlement, report, decision, or compromise secured by or on behalf of the injured person on his or her claim or right of action.".

Sec. 4. D.C. Official Code § 15-103 is amended as follows:

(a) Designate the existing text as subsection (a).

(b) A new subsection (b) is added to read as follows:

"(b) A court shall not grant an order of revival issued upon a judgment or decree the basis of which is a medical debt as defined in section 2(14C) of the Health Services Planning Program Re-establishment Act of 1996, as introduced on October __, 2025 (Bill 26-__).".

Sec. 5. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 6. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto) and a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)).