ENROLLED ORIGINAL

AN ACT

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IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

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To amend the Health Services Planning Program Re-establishment Act of 1996 to require the Department of Health to collect certain data and to require certain health care facilities to offer financial assistance and payment plans to eligible patients; to amend Chapter 38 of Title 28 of the District of Columbia Official Code to prohibit the reporting of medical debt to a credit reporting agency, wage garnishments and property liens to collect on a medical debt, and health care providers from assisting patients with completing applications for, or promoting, medical lending products under certain conditions or requiring credit card authorization before the date that health services are provided or costs are incurred; to amend Chapter 39 of Title 28 of the District of Columbia to make a violation of the restrictions on medical lending products an unfair or deceptive trade practice; and for other purposes.

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 2026".

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) The existing text is designated as Title I.

(b) Title I is amended as follows:

(1) Section 2 (D.C. Code § 44-401) is amended by adding a new paragraph (10A) to read as follows:

"(10A) "Health care facility-FAP" means a health care facility, but excluding an intermediate care facility, skilled nursing facility, or home health agency, that is required to have a financial assistance policy under title II.".

(2) Section 6 (D.C. Official Code 44-405) is amended by adding a new subsection (a-2) to read as follows:

"(a-2) Beginning one year after the applicability date of this subsection, and annually thereafter, each health care facility-FAP shall provide a written report to the Department on its financial assistance policy, including:

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

"(2) The total amount of financial assistance provided, disaggregated by amounts to provide free and discounted care;

"(3) The total number and dollar amount of outstanding medical bills owed by patients, including a list of the medical bill amount per patient and the percentage of those patients who were screened for financial assistance eligibility;

"(4) In the past year:

"(A) The number of instances the health care facility-FAP has sold medical debt to a collection entity, as that term is defined in section 201(1), including the business name of the collection entity;

"(B) The total dollar amount that has been sold to each collection entity; and

"(C) The number of instances the health care facility-FAP or collection entity acting on behalf of the heath care facility-FAP has commenced litigation against a patient to collect on medical debt, including the court in which the litigation was commenced;

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

"(6) Any other information required by the Department through rulemaking.".

(3) Section 7 (D.C. Code 44-406) is amended by adding a new subsection (e) to read as follows:

"(e) A health care facility-FAP shall establish a financial assistance policy in accordance with title II to remain in good standing for its certificate of need.".

(c) A new title II is added to read as follows:

"**TITLE II. FINANCIAL ASSISTANCE AND MEDICAL DEBT.**

"Sec. 201. Definitions.

"For the purposes of this title, the term:

"(1) "Collection entity" means a person that purchases medical debt or collects medical debt on behalf of another.

"(2) "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)).

"(3) "External review" means a review of an adverse benefit determination, as that term is defined in section 101(1) of the Health Benefits Plan Members Bill of Rights Act of 1998, effective April 27, 1999 (D.C. Law 12-274; D.C. Official Code § 44-301.01(1)).

"(4) "Financial assistance policy" means the policy required by section 202.

"(5) "Medical debt" means a debt, including a bill that is not past due, owed by a patient to a health care provider for the provision of medical services, products, or devices. The

term "medical debt" does not include charges to a credit card for the provision of medical services, products, or devices, unless the credit card is a medical lending product.

"(6) "Medical lending product" means any third-party financing, including a medical credit card or installment loan, issued under an open-end or closed-end credit plan offered specifically for the payment of medical services, products, or devices provided to a patient.

"(7) "Medically necessary health service" means a health service, including pharmaceuticals, medical supplies, and plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity, provided by a health care provider to a patient that is necessary to prevent, diagnose, or treat an illness, injury, condition or disease, or the symptoms of an illness, injury, condition or disease, and meets accepted standards of medicine. The term "medically necessary health service" does not include elective cosmetic surgery.

"(8) "Patient" means an individual who receives medical services, products, or devices, including an individual's parent or legal guardian if the individual is a minor, legal guardian if the individual is an adult under guardianship, or an individual's legally appointed healthcare agent.

"Sec. 202. Financial assistance policy requirements.

"(a)(1) Each health care facility-FAP shall establish a financial assistance policy to provide financial assistance for medically necessary health services to eligible patients residing within the facility's defined primary service area.

"(2) The financial assistance policy shall include:

"(A) Eligibility criteria;

"(B) The health care facility-FAP's basis for calculating amounts charged to patients;

"(C) The application process, including the information and documentation needed for the application;

"(D) The application review process, including the maximum number of days needed to determine a patient's eligibility;

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

"(F) The billing and collections policy, including possible actions in the event of non-payment; and

"(G) The process to ensure patients have access to, and understand, the financial assistance policy.

"(3) The financial assistance policy may not discriminate on the basis of a patient's health insurance coverage status, citizenship or immigration status, or assets.

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

"(1) Posting the policy in a prominent location on its website;

"(2) Providing written notice of the policy to patients in their preferred language during the intake and registration process and discharge, which shall be available in all languages for which the Department of Health would be required to provide translation of vital documents under section 4 of the Language Access Act of 2004, effective June 19, 2004 (D.C. Law 15-167; D.C. Official Code § 2-1933);

"(3) Posting notice of the availability of financial assistance and instructions to apply:

"(A) In high traffic areas, including the emergency department, billing office, waiting area, and other outpatient settings; and

"(B) On bills and statements; and

"(4) A disclaimer in the application materials that the patient is not required to pay the medical bill until a decision on their application has been rendered, in accordance with section 203(e).

"Sec. 203. Eligibility for financial assistance.

"(a) Except in emergency circumstances, a health care facility-FAP shall inform patients of the following information before the provision of a medically necessary health service:

"(1) If the patient is uninsured, a good faith estimate of the cost of the health service; and

"(2) If the patient is insured, a good faith estimate of the patient's cost-sharing responsibility under the patient's health insurance plan.

"(b)(1) A health care facility shall affirmatively offer to screen a patient for financial assistance if the patient:

"(A) Is uninsured;

"(B) Is participating in a federal or local public assistance program, including the Supplemental Nutrition Assistance Program, Special Supplemental Nutrition Program for Women, Infants, and Children, Temporary Assistance for Needy Families, National School Lunch Program, Low-Income Home Energy Assistance Program, Medicaid, or DC Healthcare Alliance;

"(C) Is experiencing homelessness or is at risk of homelessness, as those terms are defined in section 2 of the Homeless Services Reform Act of 2025, effective October 22, 2005 (D.C. Law 16-35; D.C. Official Code § 4-751.01);

"(D) Was previously determined to be eligible for financial assistance by the health care facility-FAP in the prior 6-month period; provided, that the patient's income or insurance status has not changed during that time; or

"(E) Satisfies any other criteria established by the Department through rulemaking.

"(2) A health care facility-FAP shall also affirmatively screen a patient for financial assistance if a member of the patient's household satisfies paragraph (1)(B) or (E) of this subsection.

"(3) A patient who is screened for financial assistance eligibility under paragraph (1) of this subsection shall be deemed eligible for financial assistance if they apply for financial assistance and provide documentation that they satisfy at least one of the criteria under paragraph (1) of this subsection.

"(c) If a patient does not meet any of the criteria set forth in subsection (b)(1) of this section, the health care facility-FAP shall screen the patient for financial assistance eligibility upon request and determine a patient's eligibility for financial assistance using:

"(1) The following proofs of income:

"(A) The patient's most recent available tax return; except, that the health care facility-FAP shall exclude any medical expense deductible;

"(B) Two recent pay stubs from all adults in the patient's household showing year-to-date income;

"(C) Proof of enrollment in a public benefits program; or

"(D) Other documentation of household income identified through rulemaking; and

"(2) Documentation of proof of residency, including a utility bill, pay stub, bank statement, government-issued identification, or attestation from a homeless shelter.

"(d) A health care facility-FAP shall provide a patient, including the patient's representative if the patient is deceased and died intestate, with the opportunity to apply for financial assistance for up to 240 days after the date of the first posted medical bill; provided, that a patient who is the subject of a collection activity by the facility or a collection entity may submit an application for financial assistance at any time and the health care facility-FAP or collection entity shall cease collection activity until the health care facility-FAP renders a decision on the application, including a determination on the amount of medical debt owed, new payment plan terms, or debt cancellation.

"(e) A health care facility-FAP shall determine whether a patient is entitled to financial assistance within 30 days after the patient files a complete financial assistance application and:

"(1) If approved, notify the patient that their medical bill has been reduced or eliminated, of any amount still outstanding, and on how to apply for additional financial assistance for any remaining balance; or

"(2) If denied, notify the patient of the denial and include an explanation of the basis for the denial of financial assistance and the process for appealing the decision.

"(f) A patient's refusal to be screened for financial assistance shall not be grounds for refusing to provide medically necessary health services or denying financial assistance if the patient later decides to apply.

"(g) The financial assistance policy shall, at a minimum, provide:

"(1) Free care to patients with a household income of 200% or less of the federal poverty level; and

"(2) Reduced-cost care to patients with a household income of more than 200% but not more than 500% of the federal poverty level by reducing the patient's out-of-pocket expenses for the health service, based on the amounts generally billed under 26 U.S.C. § 501(r)(5), by:

"(A) 75%, for a patient with a household income of more than 200% but not more than 300% of the federal poverty level;

"(B) 60%, for a patient with a household income of more than 300% but not more than 400% of the federal poverty level; and

"(C) 40%, for a patient with a household income of more than 400% but not more than 500% of the federal poverty level.

"(h) Nothing in this section shall be construed to prohibit or limit a health care facility from:

"(1) Granting financial assistance notwithstanding a patient's failure to provide one of the required forms of documentation described in subsection (c) of this section;

"(2) Granting financial assistance to patients at income levels higher than those specified in this section or to provide greater amounts of financial assistance to patients than those required by this section;

"(3) Requiring a patient to undertake good faith efforts to apply for and enroll in insurance programs for which the patient may be eligible as a condition of awarding financial assistance; or

"(4) Coordinating insurance benefits with other states.

"Sec. 204. Medical expenses payment plans.

"(a)(1) For a patient who is approved for reduced-cost care financial assistance under section 203 ("eligible patient"), a health care facility-FAP shall offer a payment plan with a monthly installment payment not to exceed 3% of the patient's monthly household income and with the first payment not due until at least 30 days after the patient is discharged or finished treatment at the facility; provided, that, upon written request by the patient, or if the patient currently has a payment plan within the same health care system as the health care facility-FAP with a higher monthly installment percentage, the health care facility-FAP may offer a payment plan with a higher monthly installment payment.

"(2) Any medical debt sold by a health care facility-FAP to a collection entity shall retain the terms of the payment plan.

"(b)(1) A health care facility-FAP shall provide each eligible patient with:

"(A) An itemized medical bill;

"(B) A document explaining the existence of a payment plan option, the eligible patient's eligibility, and how to request a payment plan; and

"(C) An opportunity to discuss with staff the payment plan option prior to the eligible patient being discharged.

"(2) An eligible patient shall have 45 days after receiving the first statement to decide whether to enter a payment plan.

"(c) A health care facility-FAP shall provide patients who enter into a payment plan with a written copy, via mail or email, of the payment plan within 21 days after the agreement, which shall, at a minimum, include:

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

"(2) The schedule of installment payments, including the expected date by which the medical bill will be paid in full; and

"(3) Information on whether late or missed payments would incur penalties.

"(d) A health care facility-FAP or collection entity may accelerate a payment plan or declare it in default or no longer operative if:

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

"(2) The health care facility-FAP or collection entity has made at least 3 reasonable attempts to contact the patient by telephone or another method of contact preferred by the patient;

"(3) The health care facility-FAP or collection entity has provided the patient written notice that the payment plan may be declared in default and with an opportunity to renegotiate the payment plan; and

"(4) The health care facility-FAP or collection entity has made a good faith effort to renegotiate the terms of the payment plan, if requested by the patient.

"(e) A health care facility-FAP or collection entity shall not commence a civil action against the patient for nonpayment until at least 90 days after the payment plan is declared in default.

"Sec. 205. Compliance and enforcement.

"(a) A violation of this title shall be considered a violation of section 17.

"(b) The Department shall make the information reported by a health care facility-FAP pursuant to section 6(a-2) and any corrective action plans or fines imposed for a violation of this title publicly available.

"(c)(1) The Department shall create a process for patients to submit a complaint relating to a health care facility's noncompliance with this title.

"(2) The Department shall review complaints submitted pursuant to paragraph (1) of this subsection within 30 days after receipt of the complaint.

"(d) The Department shall share information obtained pursuant to this title and section 6(a-2) with the Office of the Attorney General, upon request, within 30 days after the request is made.

"Sec. 206. Rulemaking.

"(a) No later than the applicability date of the Medical Debt Mitigation Amendment Act of 2026, passed on 2nd reading on June 2, 2026 (Enrolled version of Bill 26-438), the Mayor, pursuant to Title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 *et seq*.), shall issue rules to implement the provisions of this title, including:

"(1) Minimum requirements for patient appeals regarding their eligibility for financial assistance; and

"(2) The process for patients to submit a complaint to the Department pursuant to section 205(c).

"(b) The Department shall engage with health care facilities and patient advocates in the rulemaking process in order to minimize administrative costs for health care providers and ensure a streamlined application process for patients.".

Sec. 3. Title 28 of the District of Columbia Official Code is amended as follows:

(a) Chapter 38 is amended as follows:

(1) Section 28-3814 is amended by adding a new subsection (dd) to read as follows:

"(dd)(1) Notwithstanding any other provision of this section, a health care provider or debt collector shall not engage in medical debt collection until 180 days after the date the consumer receives the first posted medical bill and shall provide at least 90 days' notice to the patient before commencing medical debt collection; provided, that, if the services were provided at a health care facility-FAP, the health care facility-FAP or debt collector shall:

"(A) Include with the notice a statement that explains the availability of free or discounted care for qualifying patients and the process to apply for financial assistance; and

"(B) Not engage in medical debt collection against a patient who is eligible for financial assistance under section 203 of the Health Services Planning Program Re-establishment Act of 1996, passed on 2nd reading on June 2, 2026 (Enrolled version of Bill 26-438), unless the patient has refused financial assistance or is receiving discounted care under the health care facility-FAP's financial assistance policy and has defaulted on their payment plan.

"(2) Interest on medical debt shall not exceed 3% annually; except, that a debt collector shall not charge any interest on medical debt related to services received at a health care facility-FAP if the patient is receiving financial assistance and has not defaulted.

"(3) If a court has entered a judgment on a medical debt authorizing a health care facility-FAP or debt collector to collect on a medical debt and it is later determined that the patient was not screened for financial assistance eligibility and is determined to qualify for financial assistance, the health care facility-FAP or debt collector shall:

"(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 to 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 in compliance 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.

"(4)(A) A health care provider or debt collector who knows or should have known about an 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:

"(i) Communicate with the patient regarding the unpaid charges for the purpose of seeking to collect the medical debt;

"(ii) Initiate a lawsuit or arbitration proceeding against the patient relating to the medical debt; or

"(iii) Refer, sell, or send the medical debt to a debt buyer.

"(B) For the purposes of this paragraph, an appeal of a health insurance decision includes:

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

"(ii) An independent medical review by the health care provider providing medical services;

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

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

"(5) A health care provider or debt collector collecting on medical debt shall not:

"(A) File a property lien against a patient's primary residence, or

"(B) Garnish the wages of a patient with an annual household income less than 500% of the federal poverty level.

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

"(B) Subparagraph (A) of this paragraph shall not be construed to otherwise limit a consumer reporting agency from reporting known debts.

"(7) For purposes of this subsection, the term:

"(A) "Health care facility-FAP" shall have the same meaning as provided in § 44-401(10A).

"(B) "Health care provider" means a person whose primary business is to provide medical services, products, or devices, including a health care facility, as that term is defined in § 44-401(10).

"(C) "Medical debt" shall have the same meaning as provided in section 201(5) of the Health Services Planning Program Re-establishment Act of 1996, passed on 2nd reading on June 2, 2026 (Enrolled version of Bill 26-438).

"(D) "Medical debt collection" means debt collection of medical debt. The term "medical debt collection" does not include the act of posting the first medical bill, sending monthly statements, or an attempt to verify insurance coverage or eligibility.".

(2) A new section 28-3820 is added to read as follows:

"§ 28-3820. Prohibition on certain medical lending promotion.

"(a) For the purposes of this section, the term "medical lending product" shall have the same meaning as provided in section 201(6) of the Health Services Planning Program Re-establishment Act of 1996, passed on 2nd reading on June 2, 2026 (Enrolled version of Bill 26-438).

"(b) A health care provider, as that term is defined in § 28-3814(dd)(7)(B), 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 to a patient who:

"(A) Is under the influence of general anesthesia, conscious sedation, or moderation sedation, including any period in which the patient has been advised not to engage in activities due to such influence;

"(B) Is being administered treatment; or

"(C) Is in a treatment area, including an exam room, surgical room, or other area where medical treatment is administered, unless an area separated from the treatment area does not exist on site;

"(3) Charge a medical lending product for a medical procedure before the date of the procedure or before costs have been incurred;

"(4) Charge a medical lending product or 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) Require credit card pre-authorization or require the patient to have a credit card on file prior to administering emergency health services; or

"(6) If the services were provided at a health care facility-FAP, as defined in § 44-401(10A), offer a medical lending product or another form of credit until the health care facility-FAP has offered or conducted a financial assistance eligibility screening pursuant to section 203

of the Health Services Planning Program Re-establishment Act of 1996, passed on 2nd reading on June 2, 2026 (Enrolled version of Bill 26-438).".

(b) Chapter 39 is amended as follows:

(1) Section 28-3904 is amended as follows:

(A) Subsection (nn) is redesignated as subsection (ll).

(B) Subsection (ll) is amended to read as follows:

"(ll) violate any provision of Chapter 54 of this title; or".

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

"(mm) violate any provision of § 28-3820.".

(2) Section 28-3909(a) is amended by striking the phrase "28-3819, 28-3851" and inserting the phrase "28-3819, 28-3820, 28-3851" in its place.

Sec. 4. 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) Subsection (a) is amended by striking the phrase "have a lien upon that part going or belonging to such patient, of any recovery or sum had or collected or to be collected by such patient" and inserting the phrase "have a lien upon that part going or belonging to such patient, of any recovery or sum had or collected or to be collected by such patient; provided, that the lien shall not exceed 33% of the award" in its place.

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

"(b) Notwithstanding subsection (a) of this section, a lien recorded against a patient with health insurance injured by reason of an accident shall be limited to the amount of the patient's responsibility under their health insurance policy if the insurance claim is paid or the negotiated amount with the health insurer if the claim is not paid.".

Sec. 5. Section 15-103 of the District of Columbia Official Code is amended as follows:

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

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

"(b) Notwithstanding subsection (a) of this section, an order of revival shall not be granted for a judgment or decree to enforce the collection of medical debt, as that term is defined in section 201(5) of the Health Services Planning Program Re-establishment Act of 1996, passed on 2nd reading on June 2, 2026 (Enrolled version of Bill 26-438).".

Sec. 6. Applicability.

(a) This act shall apply 6 months after the date of inclusion of its fiscal effect in an approved budget and financial plan.

(b) The Chief Financial Officer shall certify the date of the inclusion of the fiscal effect in an approved budget and financial plan, and provide notice to the Budget Director of the Council of the certification.

(c)(1) The Budget Director shall cause the notice of the certification to be published in the District of Columbia Register.

(2) The date of publication of the notice of the certification shall not affect the applicability of this act.

Sec. 7. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 8. 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)).

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Chairman
Council of the District of Columbia

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Mayor
District of Columbia