Medicaid and Children's Health Insurance Program (CHIP)

Policy Snapshot | October 2026

DC KIDS COUNT
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Medicaid is a joint health insurance program between federal and state governments for individuals with low incomes who meet certain income, citizenship, and other eligibility requirements. As with private health insurance, Medicaid covers a wide range of medical services and procedures, such as inpatient hospital care, doctor visits, emergency services, prescription drugs, and home health care. The US Department of Health and Human Services establishes baseline eligibility, although states can broaden participation for their residents. States administer the insurance enrollment. In DC, the Department of Health Care Finance (DHCF) administers Medicaid while the DC Department of Human Services (DHS) handles applications and re-certifications. As of January 2026, in a cost-savings move to leverage more federal funding, the District started operating a basic health program called the Healthy DC Plan that, via a plan within the DC Health Exchange, serves some residents who had previously been eligible for Medicaid but with slightly fewer services covered.[1]

The Children's Health Insurance Program (CHIP), known locally as DC Healthy Families, is also a joint federal-state program. It is designed to provide seamless coverage for children in families with incomes above the federal Medicaid limit, meaning that if household income fluctuates, children do not risk loss of health coverage. CHIP also caps yearly copays at 5% of a family's annual income, calculated cumulatively across all enrolled children and all health services. In August 2026, the federal government issued new rules preventing Medicaid and CHIP from covering certain gender affirming care for young people.

Eligibility and Application Requirements

In order to qualify for coverage through Medicaid and CHIP (DC Healthy Families), individuals must meet certain financial and non-financial requirements. Financial eligibility is calculated as a percentage of the Federal Poverty Level (FPL) and the cut-off for public health insurance varies by demographic category:

Demographic Group	Federal Max Income (Baseline Eligibility for Medicaid/CHIP)	DC's Medicaid/CHIP (DC Health Families) Max Income
Children ages 0-18	Medicaid: 138% FPL CHIP: States set max income eligibility (highest eligibility state is NY at 405% FPL, lowest eligibility is Idaho at 190% FPL)	324% FPL DC has the third highest state income eligibility cap.
Youth ages 19-20	Treated as adults under federal rules (see below)	221% FPL
Pregnant women	138% FPL	324% FPL
Parents and caretaker Relatives	Under the Affordable Care Act, states may use federal funds to expand coverage for this group and set their own income-eligibility caps.	138% FPL. Prior to October 2025, DC's income limit had been 221% FPL.[2] People with incomes 138-200% FPL are now eligible for the Healthy DC plan.

1. Participants in the District's Basic Health Plan lost access to non-emergency transportation and community behavioral supports when their Medicaid coverage ended. For plan (calendar) year 2026, they also lost coverage for vision and dental insurance.
2. Appendix Table 5, "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations"

Demographic Group	Federal Max Income (Baseline Eligibility for Medicaid/CHIP)	DC's Medicaid/CHIP (DC Health Families) Max Income
Adults without children	All but 10 states cover childless adults at at least 138% FPL, as a permitted Medicaid expansion under the Affordable Care Act.	138% FPL. Until October 2025 this had been 215% FPL.[3] Childless adults with incomes 138-200% FPL are now eligible for the Healthy DC plan.
Seniors and individuals with disabilities[4]	100% FPL, not including asset requirements	100% FPL, not including asset requirements

Some groups, including children in foster care and former foster youth ages 18-26, can qualify for Medicaid without having to meet financial requirements.

Non-financial requirements for Medicaid include District residency and US citizenship or a specifically eligible immigration status, such as a lawful permanent resident (i.e., Green Card holder for 5+ years). Beginning October 1, 2026, the immigration categories that allow for Medicaid enrollment became much narrower, excluding groups like refugees, asylees, and trafficking survivors. Immigrants who are pregnant will remain eligible for health coverage through the CHIP From Conception to End of Pregnancy provision of federal policy, regardless of their immigration status; health coverage ends 60 days postpartum (far less than the postpartum year DC covers under Medicaid).

Starting January 2027, most adults ages 19 to 64 who do not have dependent children (under age 18) will be required to work, train, volunteer, or do similar activities for at least 80 hours each month to keep Medicaid coverage. Former foster youth, veterans with disabilities, and people who are medically frail can apply for a work exemption, but they will not be automatically granted; for 2027 (but not later years), self-attestation of eligibility will suffice for exemption applications.

District residents can apply for Medicaid/CHIP online through DHCF or DHS's Combined Application for Benefits. Assistance with online and paper applications is available at DHS benefit service centers and DC Health Benefit Exchanges' in-person enrollment centers or by phone.[5] Recertification in the program has historically been once a year; however, starting in January 2027, federal changes will require most adults ages 19-64 without children to renew every six months, a burden that may suppress participation.

Impact of Medicaid and CHIP/DC Healthy Families

In addition to the vast array of clinical services and long-term health benefits that public health insurance provides, research demonstrates that access to Medicaid/CHIP significantly reduces medical debt and family poverty.[6] For children, access to Medicaid/CHIP has been linked to fewer chronic conditions, less frequent hospitalizations, and increased rates of educational attainment. For youth and adults alike, the expansion of Medicaid over the years has proven to improve access to preventative care and mental health services, decrease mortality by 6%, and reduce reliance on emergency services.



3. Appendix Table 5, "Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations"
4. This group, known as the Non-MAGI-based group, is subject to a resource limit of $4,000/individual and $6,000/couple - see slide 10; the value of a home, a car, jewelry, etc. is not counted toward the resource limit. This group may also be eligible for Medicare.
5. DC Health Benefit Exchange assistance line: 1-855-532-5465
6. When medical expenses are taken into account in defining the poverty rate

Funding and Participation

Funding: For Fiscal Year 2027, the District budgeted roughly $5.13 billion for Medicaid and CHIP. Of that, the federal government is expected to cover $3.98 billion.[7] Using a payment rate known as the Federal Medical Assistance Percentage (FMAP) based on a state's per-capita income - and in the case of DC, the District's unique inability to generate revenue - the federal government currently funds 70% of DC's Medicaid costs (including CHIP).

Medicaid/CHIP participation: The most recent official DHCF monthly enrollment report shows 253,148 Medicaid enrollees in the District as of January 2026, covering roughly 36% of the District's residents. Of these enrollees, 93,955 were children under age 21. At its height of enrollment, in May 2023 when COVID-19 public health emergency rules allowed for continuous enrollment (recertification processes were suspended), DC's Medicaid program served 312,544 residents: 209,282 adults (including seniors) and 103,262 children.

Healthy DC Plan participation: As of April 27, 2026, 14,826 residents were enrolled in the new Healthy DC basic health plan according to the Health Benefit Exchange Authority.[8] The District government estimates that 2,200 residents lost coverage in the switch from Medicaid to Healthy DC due to their incomes being in the range just above 200% FPL.[9]

Coverage of children: When it comes to children's participation in public health insurance, the District has historically been a leader. Comparing the January 2026 enrollment numbers to the total population of children (under age 21), roughly 59% of children in DC were covered by Medicaid/CHIP, a figure that likely closely mirrors the proportion of children in DC who are eligible for coverage, as a 2019 study found that 96% of all Medicaid/CHIP-eligible District children were enrolled in coverage. In 2025, 43%[10] of all District births were covered by Medicaid or the Alliance, making public health insurance a critical contributor to the District's maternal, infant, and child health landscape. Additionally, Medicaid/CHIP participation is a powerful tool for reducing racial health disparities, as roughly 3 out of 4 DC children enrolled are Black and most of the rest are Latinx. Public health insurance predominantly serves children of color because, in DC, they are many times more likely than white children to be living in or close to poverty. Looking at adults, nearly 96% of all non-elderly adult DC Medicaid participants are people of color.

It is important to note that children's enrollment in Medicaid/CHIP nationally dropped by 2 million from January 2025 to April 2026, likely due, in part, to parents in mixed-status families being too afraid to get their citizen children enrolled; in the District, enrollment dropped 4.7%. This situation may get worse beginning fall 2026 as the Trump administration begins to penalize people applying for certain visas, Green Cards, or legal statuses if they or their dependents participate in Medicaid or other public assistance programs - even if they or their dependents were or currently are eligible for coverage. Taking a dependent family member's lawful receipt of public benefits into account when considering a visa or Green Card applicant's likelihood to become a "public charge"[11] is expected to deter even more families from enrolling (or re-enrolling) their U.S. born children in Medicaid. Furthermore, experts expect additional child enrollment drops nationwide when additional Medicaid red tape is fully implemented with the intent of making Medicaid enrollment and participation more difficult for everyone. When federal or local–funding for Medicaid/CHIP is reduced, bureaucratic hurdles are added, or fear of immigration penalties are increased, it is DC's Black and Brown children and families who suffer most.

7. The Provider Services rows of E-57 (excluding Alliance, Immigrant Children's Program, and Indigent Care, since these are separate from Medicaid/CHIP) of DHCF budget tables for FY27
8. Pg. 5 of Testimony of Mila Kofman, Health Benefit Exchange Director, FY27 HBX budget hearing.
9. Pg. 26 of DBX oversight responses
10. Pg. 142 of the DC Department of Health Care Finance FY25-26 performance oversight responses.
11. The "public charge" rule is an immigration test that the federal government uses to decide if someone is likely to become heavily dependent on certain public benefits for their basic needs and, if they are, to use future dependence to deny a person admission to the U.S. or lawful permanent residence (or "Green Card" status). Historically, the public charge rule looked at likelihood to rely on cash assistance (TANF) or long-term government institutional care but the first and now second Trump administration expanded the rule to consider a broader range of public benefits - SNAP, Medicaid, housing vouchers, etc - an applicant may require in the future.

Recommendations

- **Protect District residents from harmful federal changes to health insurance by:**
  - Proactively informing parents of dependent children with incomes under 138% FPL that "Section 1931" exempts them from Medicaid's new work requirements, even if their child is over age 14.
  - Using local resources to fully fund health care coverage for lawfully present residents who are losing Medicaid eligibility due to federal shifts.[12] If this is accomplished by getting them enrolled in the Alliance, that requires not cutting the Alliance in fiscal year 2028.
  - Creating seamless healthcare transition processes for pregnant individuals leveraging CHIP From-Conception-to-Birth coverage for pregnancy, birth, and postpartum care.
  - Ensuring CFSA automatically supplies documentation needed for former foster youth to be exempt from the Medicaid work requirement and assists youth in submitting forms.

- **Restore local health insurance coverage available prior to September 2025:**
  - Make Healthy DC Plan coverage comparable to Medicaid (e.g. including dental, vision, and behavioral health coverage) on an ongoing basis rather than just with one-time funding.[13]
  - Provide a way for childless adults with incomes 200-215% FPL and parents with incomes 200-221% FPL to regain health insurance coverage without paying for plans out-of-pocket through the Health Benefits Exchange.

- **Address bureaucratic Medicaid enrollment issues at District agencies that result in erroneous refusal or cancellation of Medicaid benefits**. Organizations that support clients in applying for public benefits report ongoing issues with the DHS failing to notify participants about necessary paperwork and failing to process documentation that participants submit, jeopardizing client access to healthcare.

- **Improve access to routine and specialized health care services for children.** DHCF reported an average of only 56% of children enrolled in Medicaid/CHIP received a well-child visit in FY25[14], suggesting barriers with appointment scheduling, acceptance of public insurance plans, and navigation of health service coverage. The District must look into and remove these barriers.

- **Congress should repeal barriers to health insurance coverage**, including work requirements, more frequent certifications, and the broadening of the "public charge" rule as it applies to Medicaid.

12. DC Council partially addressed this issue as described on pg. 17 of the FY27 Local Budget Act and pg. 4 of the Health Committee Report, but the Council acknowledges more action will be needed.
13. Ibid.
14. This is the percentage of eligible children receiving at least one initial or periodic screen (the ratio in measure 10 corresponding to the count in measure 9) on the Districtwide CMS-416 form.