

What Happens to Texans' Insurance Coverage When Medicaid and Marketplace Pandemic-Era Policies End?

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Executive Summary:

The COVID-19 related public health emergency (PHE) led to federal legislation that changed the landscape of Medicaid and Marketplace insurance coverage. Beginning in 2020, policy responses led to increasing Medicaid enrollment due to federal rules preventing Medicaid disenrollment, and increased Marketplace participation through generous subsidies extended to the majority of the working age population without access to employer provided coverage. In this brief, we describe and summarize the implications of the federally declared PHE and federal legislation for health insurance coverage during the 2020-2022 period in Texas at the state and county level, estimate the implications for insurance coverage once the PHE ends, and provide estimated aggregate fiscal impacts. Texas had the nation's highest uninsurance rate at 18.4% in 2019, but since January 2020, total Texas Medicaid caseload has increased by 41% or 1.6 million people (as of June 2022), and about 750,000 individuals have newly enrolled in Marketplace coverage, likely substantially decreasing the number uninsured. The Medicaid policies have provided a net financial windfall to the state of \$3.5 billion since January 2020. With the eventual end of the PHE, our conservative estimates expect that 550,000 to 700,000 individuals will lose Medicaid coverage, increasing the uninsurance rate by at least 2 percentage points or about 10%.

Attention to policies and administrative actions that support ongoing insurance enrollment can help ensure that the large gains to insurance coverage achieved during the PHE can be sustained. Policies and administrative actions that would help ensure the historic gains in coverage are maintained include reducing red-tape costs of processing renewals and redeterminations by streamlining eligibility systems (including the use of information already available to the state), using the capacity of managed care and health insurance navigator organizations for outreach and processing, and taking advantage of increased federal matches for Medicaid expansion.

Introduction

The landscape of subsidized health insurance coverage has changed significantly since the federal declaration of the public health emergency (PHE) in March 2020, due in large part to changes in Medicaid and Marketplace policies. Downturns typically increase unemployment and lead to the loss of employer-sponsored health insurance, increasing the number of lower-income people without health insurance and hence demand for Medicaid coverage.¹ In order to prevent health insurance losses during the pandemic and related recession and to provide financial support to state governments, some key new federal policies were passed by Congress. Since the onset of the PHE, state Medicaid programs have adopted a maintenance of effort (MOE) continuous eligibility provision first specified by the federal Families First Coronavirus Recovery Act (FFCRA) in 2020, and as a result enrollment in Medicaid has increased substantially in every state. Under the American Rescue Plan Act (ARPA) of 2021, Marketplace subsidies on the Affordable Care Act's (ACA) Marketplace were expanded for the first time to people with incomes over 400% of the federal poverty level (FPL) and increased for those with incomes 100-400% FPL, representing large declines in the out-of-pocket price of health insurance for these populations.

In this brief, we outline the implications of these policy changes in the Texas context by describing and analyzing data from public survey (the American Community Survey) and administrative data (State of Texas Department of Health and Human Services, Center for Medicare & Medicaid Services). We provide estimated total insurance coverage gains during the pandemic period and projected potential coverage losses as these policies are expected to expire. We also provide estimated fiscal impacts for Texas and discuss their implications.

Understanding the growth and change in composition of health insurance enrollment during the PHE is important for several reasons. The degree to which enrollment will remain high has implications for state budgets, in particular with a coming return to pre-pandemic federal matching rates for Medicaid with the end of the PHE and the expiration of enhanced Marketplace subsidies at the end of 2025. A substantial portion of current Medicaid enrollees will no longer qualify for subsidized coverage when the PHE declaration expires, regardless of whether their income, household, or employment circumstances differ from today. To maintain historic gains in coverage, states need to prepare to help transition these members to other sources of coverage. The impacts of these PHE-era policies, despite their special circumstances, can also inform future policy in states like Texas where the focus is on maximizing health insurance coverage under existing options.

Medicaid Policy Changes Under the PHE

FFCRA increased the federal share of Medicaid funding to states by 6.2 percentage points from January 1, 2020, through the last day of the calendar quarter in which the PHE ends, requiring that states do not disenroll Medicaid beneficiaries. Since March 18, 2020, Medicaid members have not been subject to eligibility

redetermination or disenrollment, regardless of whether life changes might normally have rendered the beneficiary ineligible. They normally would need to complete annual eligibility renewals, report changes in income and other circumstances, and otherwise respond to income verification requests, all of which can result in ending or disrupting coverage even for the eligible. The only ways for beneficiaries to lose coverage are by specific request, by moving out of state, or in death. This policy has major implications for insurance coverage and for the state fiscal environment.

As noted above, many individuals who remain enrolled may no longer satisfy categorical or means-tested eligibility criteria under the usual Texas rules. For example, people in the pregnant women eligibility group generally qualify for coverage if their household income is below \$3,022 per month for a family of 2 or approximately 190% FPL.² Someone who is no longer pregnant and past their usual post-partum eligibility period of 6 months would normally be disenrolled from Medicaid coverage unless their incomes were sufficiently low to qualify as a Medicaid parent (\$251 per month for a family of 3 or about 14% FPL), however, the PHE has allowed them to remain covered regardless of income. Likewise, a child who normally would have aged out of coverage eligibility is still covered, as is a child whose parents' income has increased past the eligibility threshold for Children's Medicaid (\$2,559 per month or 133% FPL) and would typically be transferred to CHIP (if income remains below 200% FPL) or lose eligibility for public coverage (if income were higher than 200% FPL).

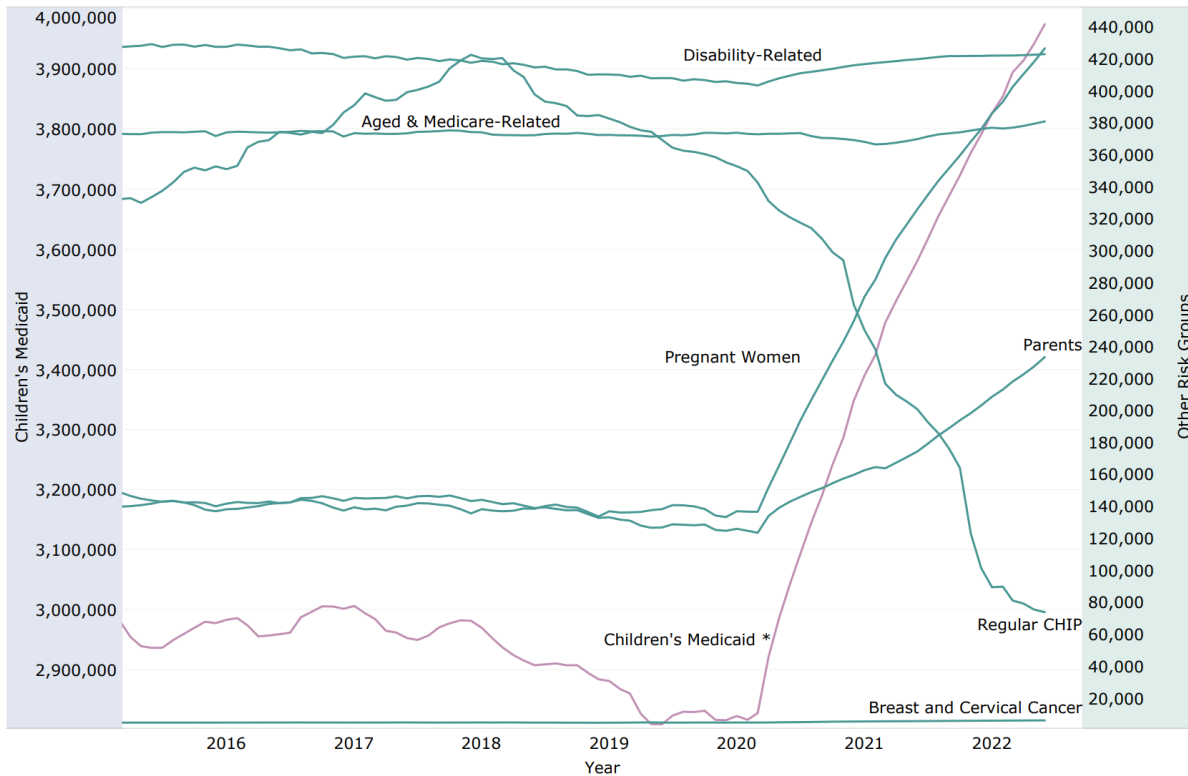
The vast majority of those who are currently enrolled, including some of the growth in caseload, will likely still be eligible for coverage when the PHE expires. This is because reasons for losing coverage are not always simply due to not satisfying eligibility rules. Administrative disruptions to coverage can occur during the process of receiving and completing the required paperwork associated with renewals of Medicaid coverage. Every Medicaid member will need to engage in the renewal process after the PHE ends in order to affirm ongoing eligibility in their current or updated eligibility group or terminate enrollment.

Understanding how much higher caseloads are due to ineligibility vs. administrative barriers is an important question but difficult to gain traction on, since survey data historically suggest a large fraction of those eligible for Medicaid are not actively enrolled at a given point in time. Dague et al. (2022) estimate the degree to which higher Medicaid enrollment during the PHE reflects continuous coverage and suspended disenrollment vs. pandemic economic circumstances, showing that the vast majority of increased enrollment is attributable to the disenrollment freeze.³ That finding is consistent with a prior, puzzling set of papers that showed that increased federal funds were not strongly correlated with changes in Medicaid enrollment nationally⁴, that insurance coverage remained steady, unlike in previous recessions, with a larger increase in public coverage than decrease in employer-sponsored insurance,⁵ and weak correlations between Medicaid enrollment increases and unemployment rates.^{6,7}

The state fiscal implications of MOE policy are also significant. Medicaid has been jointly financed between the federal and state governments since it began in 1965. States receive a matching grant from the federal government to help finance their individual state programs that depends on a three year running average of state per capita income; in Texas, this rate is currently 59.87% (not including the FFCRA increase). One can think of the matching rate as the “sticker price” for anyone newly enrolling in Medicaid. For every dollar a state spends, the federal government matches that dollar $FMAP/(1-FMAP)$, so an FMAP of 60% would mean that every state dollar brings \$1.50 (0.6/0.4) in federal spending to the state. Because the FMAP is already in place and can be quickly distributed through existing quarterly payment systems, it is a mechanism the federal government can easily use to increase aid to states. We can divide the change in state Medicaid spending under the MOE into a windfall: the additional dollars from the 6.2 percentage point FMAP bump that the state is gaining on the population that would always be enrolled, and a commitment: the additional dollars the state must spend because of increased enrollment in order to comply with policy that brings down the federal match windfall (the state’s share of the “excess” caseload). The amount of the commitment is increasing over time because an increasing proportion of the caseload is enrolled only due to the MOE policy, so understanding the relative proportions is important for budget forecasting, particularly as the PHE expires and states have a limited time to return to the status quo.

In Figure 1, we show trends in Texas Medicaid enrollment by eligibility group over time. Note that the vast majority of the Texas caseload is children, and they correspondingly account for the majority of the increased caseload; in Figure 1, children’s caseload is graphed on the left axis while all other eligibility groups are graphed on the right axis. Total caseload has increased by 41% or 1.6 million since January 2020 (as of June 2022). Pregnant women had the highest relative growth in caseload (211%), followed by parents (85%), children (41%), breast and cervical cancer (27%), disabled-related (4%), and aged/Medicare-related (2%). Part of the increase in children’s Medicaid coverage has been offset by a 79% decline in regular CHIP participation, suggesting that some of the children who are still enrolled in Medicaid because of MOE would typically have transitioned to CHIP due to fluctuations in family income. Including CHIP in the calculation for children results in a net increase of 27% (870,000), and in analyses that follow below we consider the net total of Children’s Medicaid and regular CHIP.

Figure 1. Texas Caseload by Eligibility Group, 2015-2022



Notes: Figure shows caseload by eligibility group over time (March 2015 until June 2022). Data sourced from Texas Health and Human Services Healthcare Statistics *Medicaid and CHIP Monthly Enrollment by Risk Group*. * indicates that the Children's Medicaid caseload is shown on the left axis. All other risk groups are shown on the right axis.

The increase may not be fully attributable to the MOE policy, as there would have been some increases in caseload due to the economic recession and changes in population. We describe below how we model Medicaid caseloads and two different ways to think about attributing changes in caseload to the policy.

Overview of ACA Marketplace Policy in the Pandemic Era

The Affordable Care Act (ACA), passed on March 23, 2010, reformed the individual health insurance marketplace to provide broad and affordable coverage to individuals without access to employer sponsored health insurance coverage.⁸ The new centralized state and federal Marketplaces for individuals to purchase subsidized insurance began operating on January 1, 2014 - covering over 8 million individuals across the U.S. and 773,757 in Texas in its first year of operation.⁹ Political pressure to change the ACA led to many attempts to repeal the law. However, the only major legislative change was the elimination of the individual mandate starting in calendar year 2019.¹⁰ Concerns that the individual marketplace would unravel did not materialize.^{11,12} Premium costs increased but did not unravel the market.¹³ By 2022 national enrollment grew to 14.5 million and 1.8 million in Texas.^{14,15}

The ACA made premium tax credits available to individuals buying a Marketplace insurance plan if a person’s income in the calendar year is expected to be within 100% to 400% of the federal poverty limit (FPL). To maintain adequate cost-sharing for individuals, the subsidy was tied to the premium cost of the second cheapest benchmark silver plan available to consumers in a market. To promote competition and allow consumers to choose their preferred plan, the subsidy was not tied to a specific health plan. Instead, the subsidy amount is based on the second cheapest silver plan (the benchmark plan) and this subsidy could be applied to any plan. To illustrate, the first column in Table 1 provides an overview on the maximum out of pocket premium costs for individuals by income relative to the FPL prior to and following ARPA. For example, prior to ARPA a 45-year-old making \$27,180 per year or 200% of the FPL in 2022 would have to pay no more than \$148 per month for a benchmark silver plan or 6.52% of income. If the benchmark plan’s premium was \$550, then a 45-year-old would get a premium tax credit subsidy of \$402 per month towards the plan while the out of pocket premium cost would remain the same. On the other hand, a 45-year-old making \$54,400, or 401% of the FPL, would not receive any subsidy and would have to pay the full premium.

Table 1 – Subsidy Calculation by Income

Income (% of FPL)	Enhanced PTCs Expire (Old Policy)	Enhanced PTCs are Extended (New Policy until 2025)
<138	2.07	0
138-150	3.10-4.14	0
150-200	4.14-6.52	0-2
200-250	6.52-8.33	2.0-4.0
250-300	8.33-9.83	4.0-6.0
300-400	9.83	6.0-8.5
400+	na	8.5

Notes: Subsidy Calculation for each income group by % of Federal Poverty Line based on ACA and ARPA law. Source: KFF Health Reform “How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who are Uninsured.”

One feature of the subsidy meant that a 45-year-old making \$27,180 per year could apply the \$402 per month subsidy to any plan of their choice. For example, a cheaper plan, such as a bronze plan with a lower premium cost of \$480 per month, would reduce the out-of-pocket premium spending for the individual to \$78 per month. In some cases, bronze plans were priced at or below the subsidy individuals qualified for, leading to the opportunity to buy a plan without any out-of-pocket premium contributions.¹⁶

The American Rescue Plan Act, signed into law on March 11, 2021, made two important changes to the ACA’s subsidy schedule for individuals purchasing coverage on the individual Marketplace. Specifically, it increased the subsidies for individuals making between 100% and 400% of the FPL by reducing the out-of-pocket premium contribution limits and by expanding subsidy eligibility for the first time to those

making more than 400% of the FPL (see Table 1 column 2).¹⁷ Additional changes were made in ARPA to increase enrollment and to limit uninsurance due to job loss and transition during the COVID period. The Biden administration opened a six-month pandemic-related special enrollment period in 2021 and substantially increased funding for outreach and consumer assistance, leading to record enrollment in Marketplace plans by the end of the special enrollment period. Further, people receiving Unemployment Insurance (UI) in 2021 were treated as though their income was no more than 133% of FPL for the purposes of the premium tax credit, thereby providing generous subsidies, leading to zero out of pocket premium cost and access to affordable health insurance to those who experienced an unemployment spell in 2021, including those who might otherwise have fallen into the coverage gap in states like Texas, which have not expanded Medicaid.¹⁸

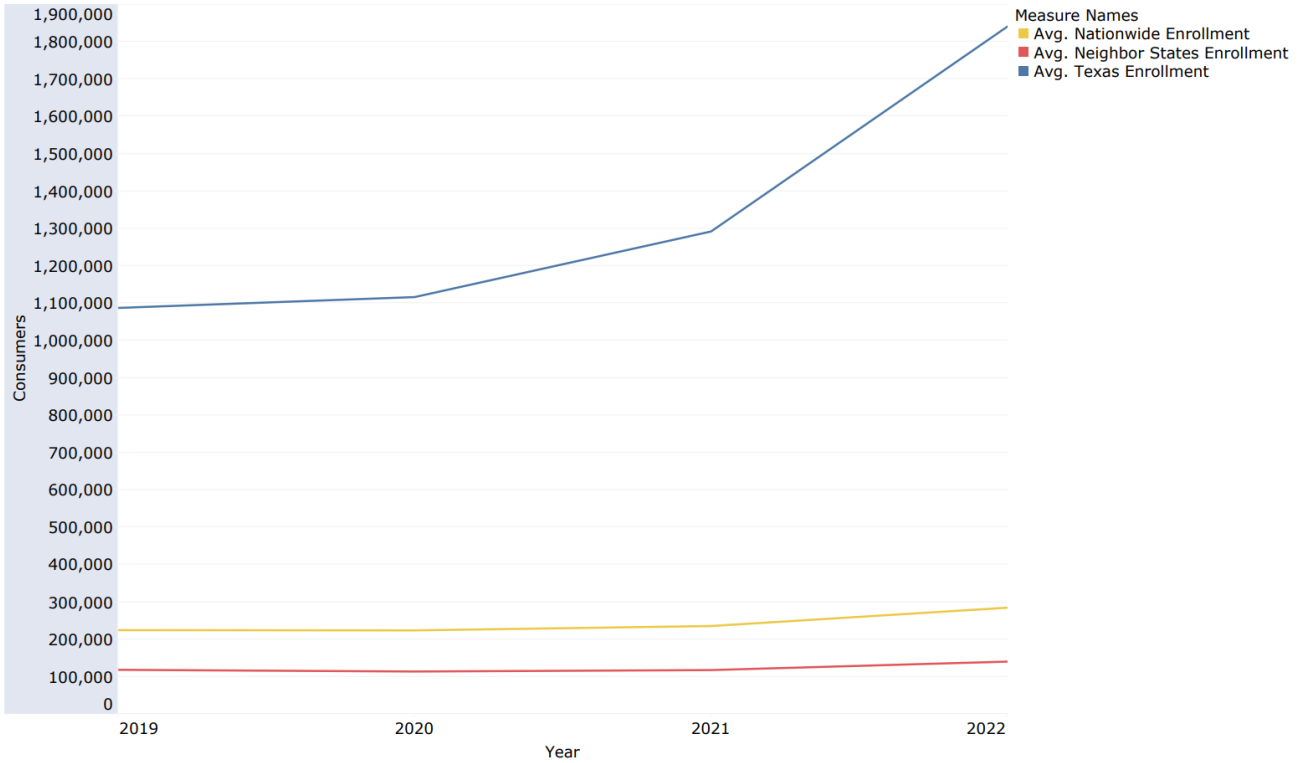
As a result of these temporary Marketplace changes in 2021, many new individuals were able to purchase coverage and those who enrolled in the Marketplace plans saw their premium contributions decrease – many qualifying for a \$0 premium per month plan. Further, high-income individuals were able to purchase coverage for the first time with premium tax credits. In previous years, few individuals making more than 400% of the FPL enrolled due to cost. The new ARPA Marketplace subsidy rules led to average premium savings estimated to be \$70 per person per month for those making between 100% and 400% of the FPL in 2021.¹⁹

Of note is that the ARPA increased premium tax credits were temporary, and the increased premium tax credits were set to expire at the end of 2022. Individuals enrolling for coverage in November 2022, with coverage starting on January 1, 2023, would observe higher premium contributions for the same plan. It was estimated that the sunset of the law will lead to 3 million individuals losing coverage nationally. However, budgetary reconciliation discussions led lawmakers to expand the ARPA enhanced premium tax credits and expanded income eligibility for subsidies through the end of 2025 as part of the Inflation Reduction Act (IRA) signed on August 16th, 2022.²⁰

Texas was already one of the largest individual marketplaces prior to ARPA, but still had the highest uninsurance rate in the nation. This suggests ample room for increases in coverage in 2021 and beyond, especially given that many low-income individuals qualify for zero cost or low cost health plans in the years to come. Figure 2 displays the trend in annual nationwide (39 states) average state level enrollment, average state level Texas, and average surrounding states enrollment (AZ, NM, KS, LA, MO, AR, OK). While enrollment increased nationally and in surrounding states, Texas saw the largest nominal increase in enrollment of about 70% by 2022 relative to 2020, rising from 1.1 million enrollees in 2020 to 1.3 million in 2021 and 1.8 million in 2022. One reason for the large jump from 2021 to 2022 could be that the first regular open enrollment in November of 2021 allowed individuals to see the new lower out of pocket premium prices when selecting plans online, which was not the case when individuals selected plans in the fall of 2020 for 2021, as the legislation had not yet been passed. As such, the 2021 increased premium subsidies may not

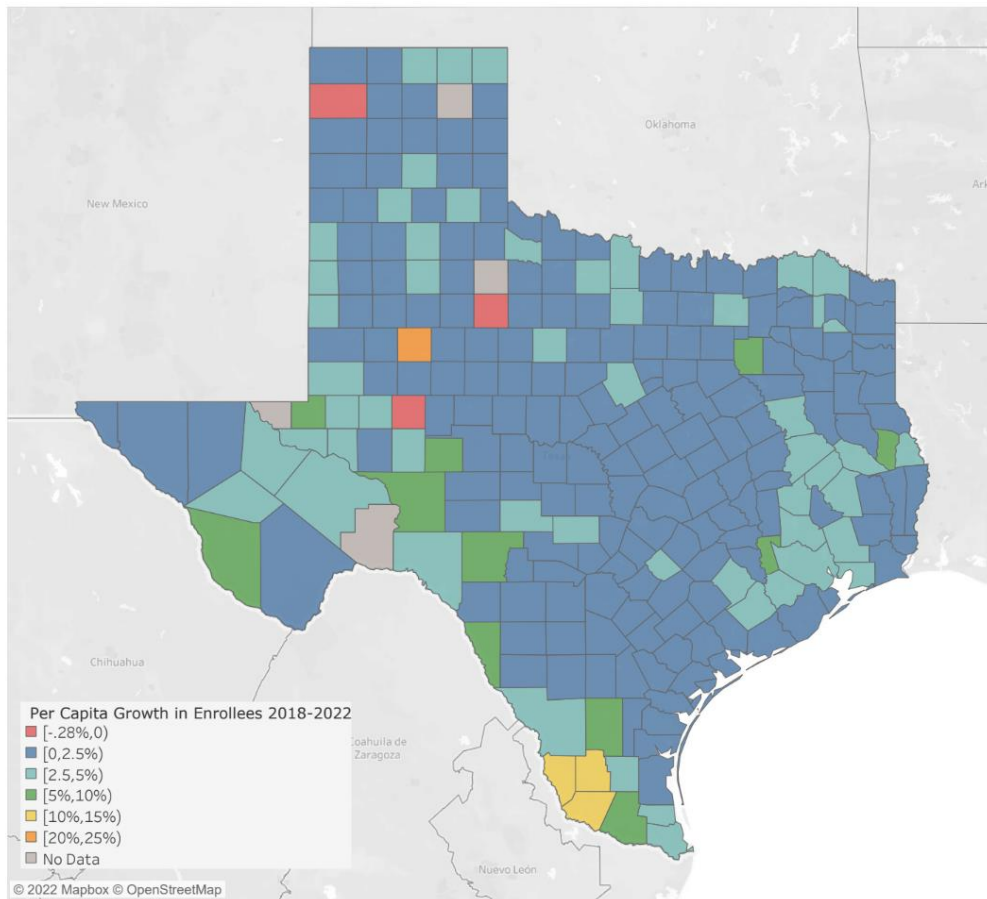
have been noticed by many individuals until 2022, even with the increased outreach and the special six-month open enrollment period in 2021.

Figure 2 – Average State Level Enrollment Trends



Notes: Annual Average Enrollment Trends for Texas, neighboring states, and nationwide. Data Source: CMS PUF Data Files

Figure 3 – Growth in Count Marketplace Enrollees



Source: Authors' calculations from CMS PUF data.

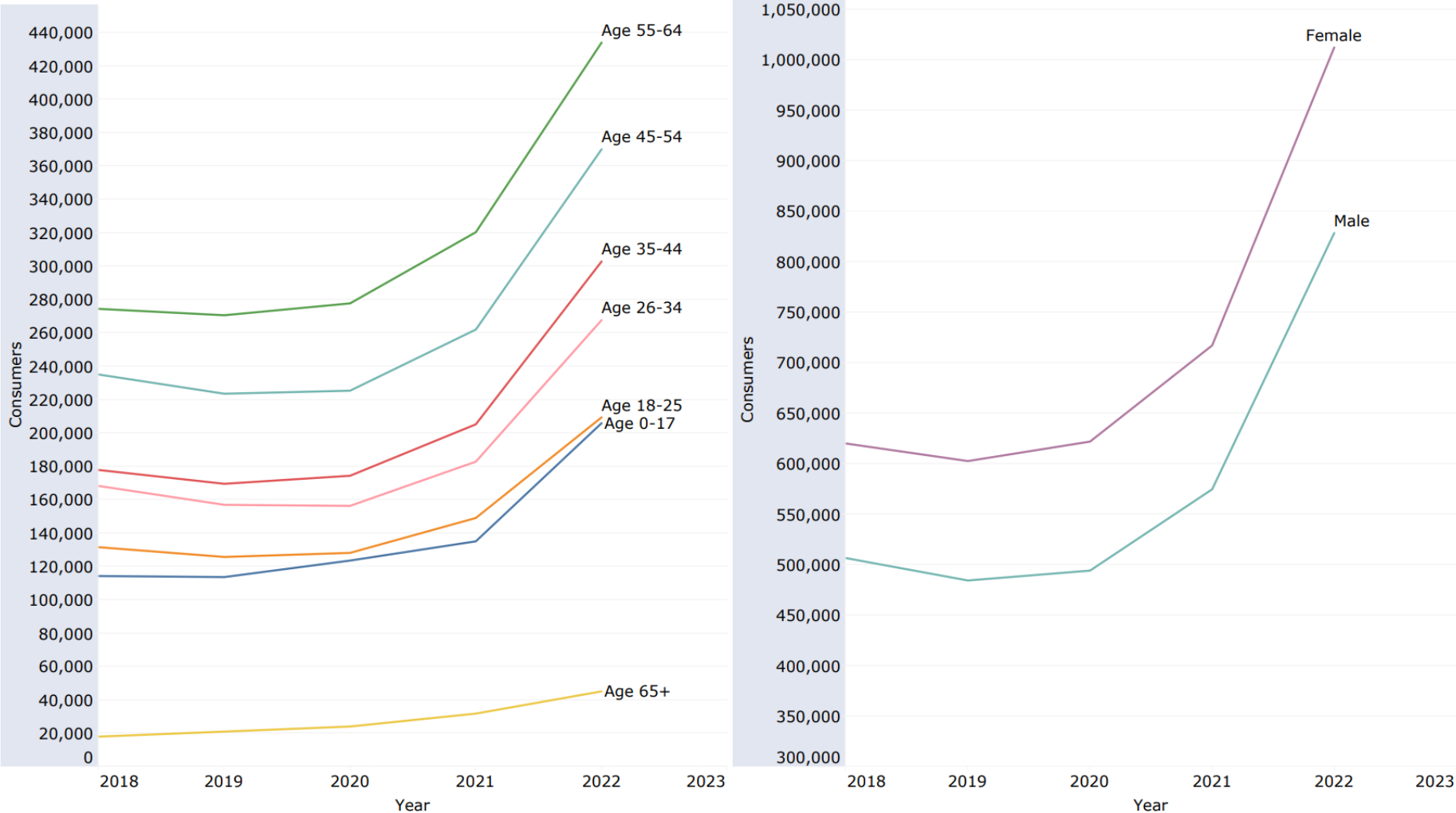
Figure 3 displays the growth in the per capita number of enrollees in each county from 2018 to 2022, suggesting that growth was especially strong in suburban and rural counties. Growth rates per capita were calculated based on total enrollment divided by the county level population reported in the 2016-2020 5-year American Community Survey estimates. Since rural county populations are generally older and more female than urban counties, one can expect demographic difference in enrollment profiles. Decomposing enrollment growth by demographic groups (age and gender) displays that the enrollment gains were especially strong among those aged 35-64 and equally strong for men and women (Figure 4). Since older individuals generally face higher premiums, they may have been especially enticed to enroll under the generous ARPA subsidies.

In Figure 5 we show that the majority of enrollment gains were concentrated in silver plans and that the average out of pocket premium decreased from about \$120 in 2020 to about \$60 in 2022 in Texas. Of note is that the average out of pocket premium did not change in 2021, even though premium subsidies were as generous

as in 2022. This may be due to the relatively small increase (about 20%) in enrollment in 2021 compared to 2020 and because the mix of selected plans shifted towards higher priced plans.

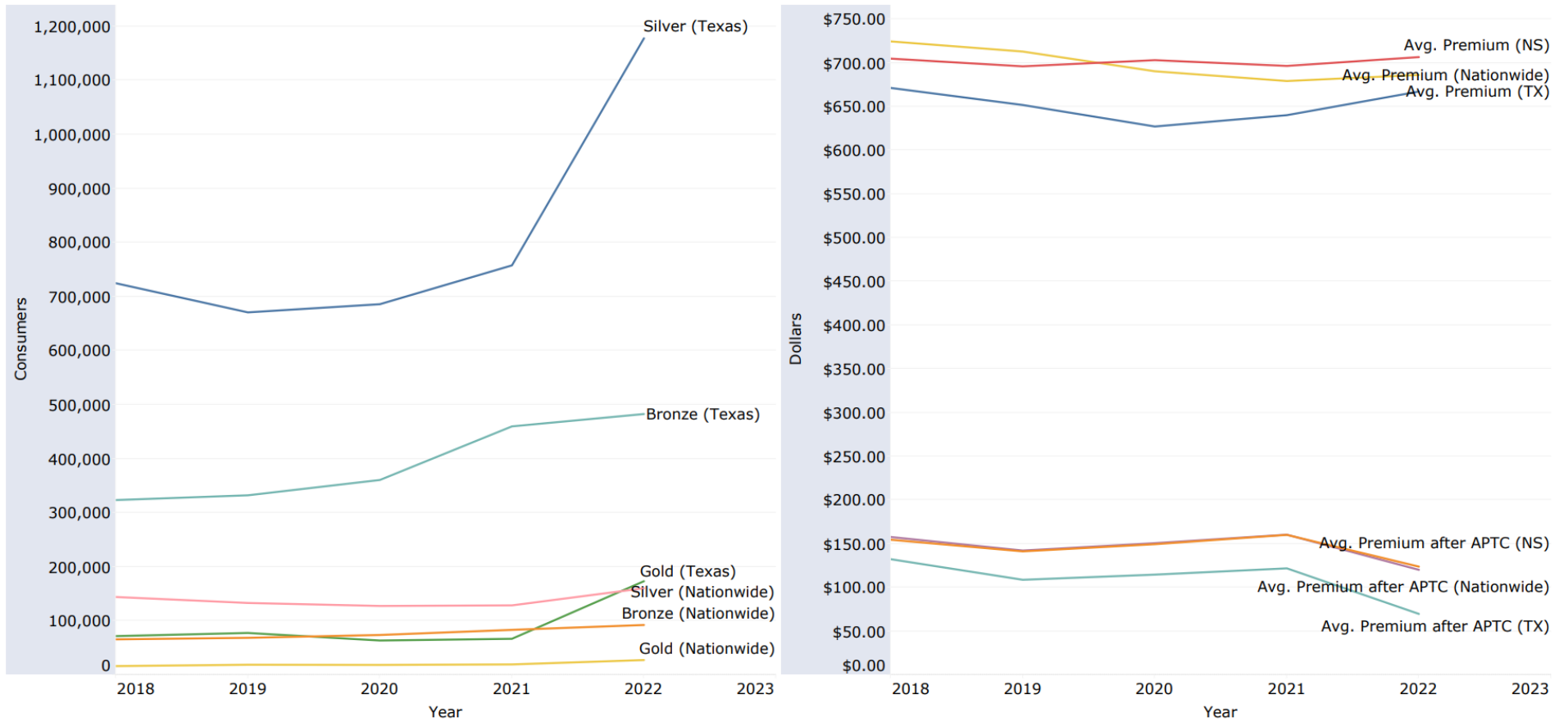
Figure 6 displays the growth in Marketplace plans by county from 2020 to 2022 and shows that almost all counties saw an increased number of offered plans, especially in urban and suburban counties, with the average county seeing 5 plans compared to 3 plans in 2020.

Figure 4 – Marketplace Enrollment by Age and Gender Trend



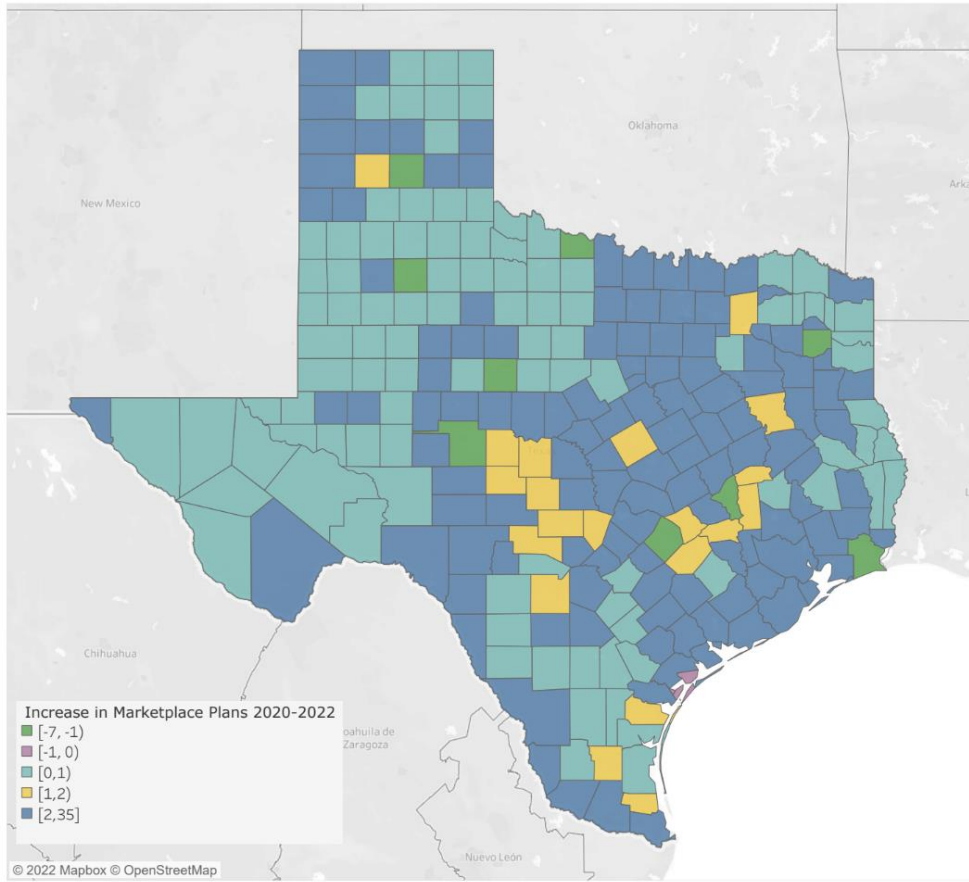
Notes: Figure shows number of Marketplace Consumers in Texas by age group and by gender. Source: CMS PUF Data Files

Figure 5 – Marketplace Plan Choice and Premium Trends



Notes: Left side shows the trend in number of consumers per plan (Bronze, Silver, Gold) for Texas, neighboring states, and nationwide. Right side shows the trend in average premium costs and average premium costs after Advanced Premium Tax Credits (APTC) for Texas, neighboring states, and nationwide. Source: CMS PUF Data Files

Figure 6 – Growth in Marketplace Plans by County



Source: Authors' calculations from CMS PUF data.

Impacts of Pandemic-Era Policies and Coverage Projections

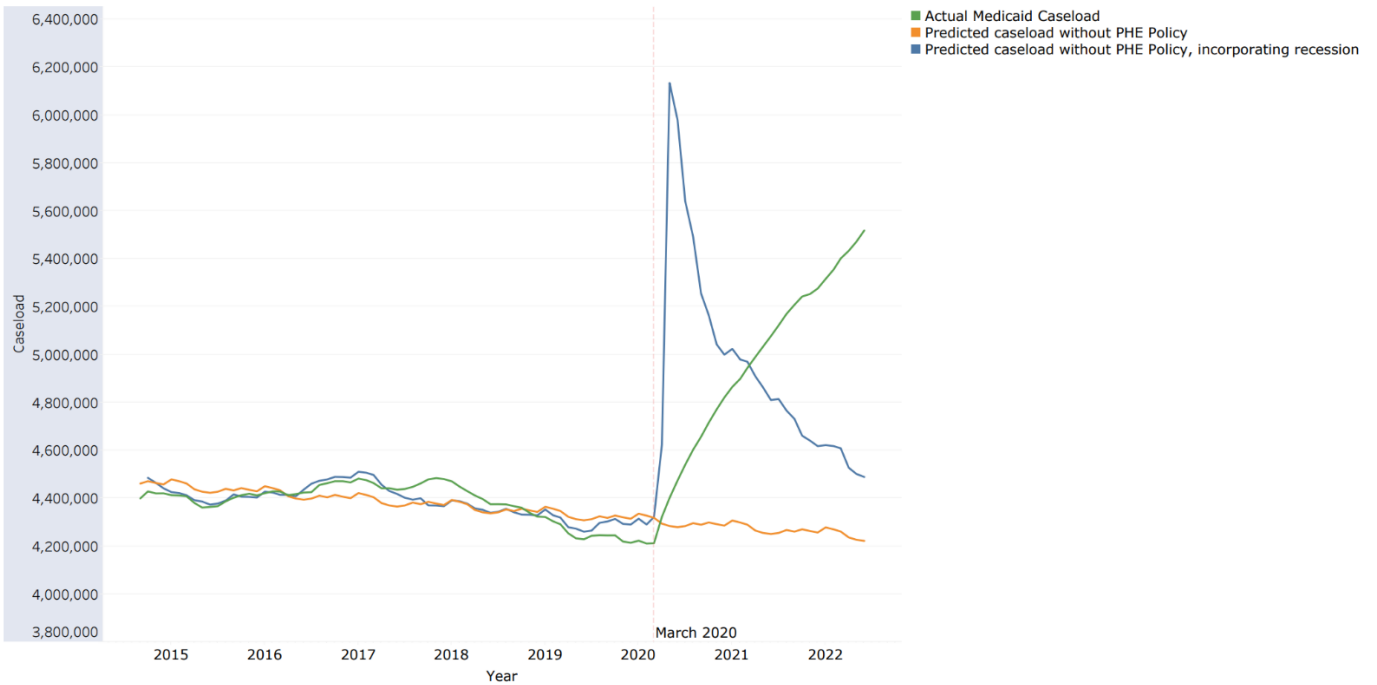
Both the Medicaid and Marketplace policies are temporary. The Medicaid continuous enrollment provision will expire on the last day of the quarter following the end of the PHE. The Marketplace policies, while recently extended through the end of 2025, will also most likely expire at some point. In order to understand the potential impacts of the expiration of these policies in Texas, we estimated how many people might lose coverage in the 12 months after the PHE expires as Medicaid redeterminations progress. We also estimate the impact of the expiration of the Marketplace subsidies, though we assume that current Marketplace policies will be ongoing through the end of 2025.

To estimate the impact of the end of the PHE on Medicaid caseload, we use modelling techniques that allow us to extrapolate trends in expected caseload based on historical data. In other words, the goal is to understand how many Medicaid

enrollees are only enrolled in Medicaid due to the PHE. Specifically, we use monthly Medicaid caseload data from 2014-2019 to estimate a trend in caseloads while adjusting for seasonality and in some cases, the rate of unemployment. We account for unemployment coverage as it is a known determinant of increases in Medicaid caseload and because unemployment increased substantially with the COVID-19 pandemic in 2020.²¹ The modelling results allow us to predict caseloads to the 2020-2022 period had unemployment not changed and changes in caseload due to the spike in unemployment in the early pandemic recession. We perform this analysis for the overall aggregate Texas Medicaid caseload by Medicaid eligibility group and at the county level. See the Technical Appendix for further details on the estimation.

A summary of the aggregate Medicaid model predictions is found in Table 2 and illustrations can be seen in Figure 7. In Figure 7, the green line shows total actual Medicaid caseload (including CHIP), the orange line (Model 1) shows the predicted level of caseload with no pandemic, and the blue line (Model 2) shows the predictions that account for the increases and eventual declines in the unemployment rate. Model 1 predicts an ongoing downward trend in caseload that started before 2020, which is unlikely to provide an appropriate trend for the pandemic period due to the related recession and spike in unemployment. For this reason, we prefer estimates from Model 2. Although Model 2 seems to overpredict the increase in caseload in early 2020, due to the temporary spike in the unemployment rate, Model 2 also provides a better match for trends in the earlier pre-2020 period and captures the expected downward trend in caseload associated with the economic recovery.

Figure 7. Predicted vs. Actual Aggregate Medicaid Caseloads



Notes: Shows the actual total Medicaid caseload (including CHIP), the predicted Medicaid caseload from Model 1, and the predicted Medicaid caseload from Model 2. Source: Authors’ calculations from Texas DHHS and Workforce Commission data.

Table 2 shows the actual and model-predicted total caseloads for each group measured in June 2022 as well as the difference relative to predicted for both models, although we focus our discussion on Model 2. Overall, excess caseload is predicted to be 1,029,421 by June 2022, though three Medicaid groups make up the majority of the excess caseload. Specifically, 4,048,531 children were covered by Medicaid, though our preferred model suggests that, without the PHE, only 3,438,193 would have coverage. The nominal excess caseload is largest for the children’s Medicaid program (610,338), followed by pregnant women (288,879), and parents (97,430). These three groups account for 96% of the excess Medicaid caseload – with children accounting for 59% of the total excess caseload followed by pregnant women (28%), and parents (9%), and with the disabled, aged/Medicare, breast/cervical cancer groups constituting the remainder (<4%). Table 2 makes it clear that the largest relative increase in coverage has been among the pregnant women eligibility group, with enrollment more than 210% higher than predicted by Model 2 (more than three times higher than predicted), followed by the parental eligibility group, which is 72% higher than predicted, the breast/cervical cancer group (37%), children (18%), the disabled (6%), and aged/Medicare (2%), with total caseload 23% higher than predicted by Model 2.

Our predictions of Texas excess caseload are larger than the Kaiser Family Foundation’s nationwide projections of between 5% and 13%, which would imply 275,903-717,348 for Texas.²²

Table 2. June 2022 Actual vs. Predicted Medicaid Caseloads

Model	Children (Medicaid + CHIP)	Disabled	Aged/ Medicare	Pregnant Women	Parents	Breast/ Cervical Cancer	Total
Actual	4,048,531	422,816	380,727	426,432	233,371	6,185	5,518,062
Predicted, Model 1	3,193,187	396,205	370,953	135,568	121,397	4,548	4,221,858
Difference	855,344	26,611	9,774	290,864	111,974	1,637	1,296,204
% Difference	27%	7%	3%	215%	92%	36%	31%
Predicted, Model 2	3,438,193	400,581	371,861	137,553	135,941	4,512	4,488,641
Difference	610,338	22,235	8,866	288,879	97,430	1,673	1,029,421
% Difference	18%	6%	2%	210%	72%	37%	23%

Notes: Authors’ calculations from Texas DHHS and Texas Workforce Commission data.

On the fiscal side, we use the model to provide a sense of the magnitude of the windfall vs. commitment associated with the MOE. Initially, 100% of the change due to MOE policy was windfall, with the state receiving the 6.2% increase on its full caseload beginning in January 2020, so at 2019 reported per-enrollee per month costs by group,²³ the total monthly windfall would be more than \$160 million with a commitment of zero. Note that in the calculations that follow, if the model predicts higher caseload than actual for a risk group, as it does particularly in 2020, we define the commitment as zero and use actual enrollment to calculate the windfall. Over time, the commitment grows; in January 2021, the windfall was \$170 million with a commitment of \$23 million from the state, resulting in a net financial gain of \$147 million in that month from the policy. If calculated based on the June 2022 difference in predicted vs actual caseload from Model 2, the June 2022 commitment would be approximately \$141 million, which is much closer to the June 2022 calculated windfall of \$164 million; the state maintains a large net windfalls on its aged and disabled populations and a small one for children, but the commitment required to sustain increased caseload in the pregnant women and parent categories has grown large enough to offset a large portion of the windfall. In order to understand the total net increase in federal dollars compared to the state’s required spending, one would need to sum across all months since January 2020, which yields a total of more than \$3.5 billion in total net gain to the state through its Medicaid programs from the policy

through June 2022. Our total is somewhat lower than a similar estimate from the Kaiser Family Foundation, which covers the full federal fiscal year 2022.²²

Changes in statewide and county Marketplace enrollment and Medicaid caseload (derived from Model 2) are presented in Table 3 alongside predicted changes in uninsurance associated with exiting the PHE. We calculate that the ARPA policies led to an increase in Marketplace coverage of about 750,000 individuals in Texas and note the changes in Marketplace coverage by county in the table. As such, an elimination of the ARPA subsidies would likely lead to a decrease in marketplace enrollment of about 750,000 individuals. Our estimates on the impact of the enrollment gains due to the ARPA Marketplace subsidy increase are in line with other projections from the Urban Institute and the Assistant Secretary for Planning and Evaluation (ASPE) who expect decreases in enrollment of 767,000 and 833,000, respectively, after the expiration of the ARPA subsidies.^{24,25}

To arrive at our predicted change in uninsurance after the PHE, we assume that changes in uninsurance are a function of the excess Medicaid caseload estimated using Model 2. However, re-determination may lead some enrollees, especially pregnant women and children, to re-enroll in Medicaid or, if ineligible for Medicaid coverage, to enroll in the Marketplace. This is also known as the welcome mat effect, which suggests that increased awareness of (new) coverage opportunities can lead to elevated sign-up of already eligible individuals.^{26,27} In terms of the upcoming end of the PHE, this implies that Medicaid coverage during the PHE may lead individuals to continue to seek coverage after the PHE. This coverage search may lead to re-enrollment in other Medicaid or CHIP programs or coverage through the Marketplace. The end result is that the overall level of coverage is expected to be higher than before the pre-PHE period.

We make some assumptions about the take-up rates of Medicaid and Marketplace coverage as Medicaid redeterminations occur that are detailed in the Technical Appendix. We also include a different scenario in which we abstract from the modelling approach and assume that redetermination will lead to 18% disenrollment consistent with estimates from the federal government.²⁸ Overall, we anticipate that the end of the PHE will lead to an increase in statewide uninsurance of between 550,000 and 730,000 children and adults. Table 3 provides these estimates overall and by county. For some very small counties, we were unable to provide reliable estimates.

We also perform an additional analysis that provides insight into the county-level number and share of individuals that remain uninsured by 2022, but who may be eligible for the Marketplaces. Specifically, we use data from the 5-year 2020 ACS to estimate the number of uninsured individuals eligible for subsidized Marketplace coverage in 2020. These are uninsured individuals who are between 18 and 64 years old and have a household income between 100% and 400% of the FPL. Accounting for the increase in Marketplace take-up between 2020 and 2022, we estimate that about 70% of individuals likely eligible for subsidized Marketplace coverage remain

uninsured in Texas. The share of uninsured but likely Marketplace-eligible individuals varies by county, with some counties having few remaining uninsured individuals and others having a large share remaining uninsured.

Limitations

There are some limitations to these estimates. The models rely on aggregate data, so we have no information about the underlying characteristics of the individuals, including their income or prior history of Medicaid enrollment, which might be useful in understanding their ongoing likelihood of eligibility and enrollment. Furthermore, the COVID-19 PHE and related recession were unprecedented, and our counterfactual predictions rely strongly on assumptions that caseloads would have followed similar patterns as they did historically. For the fiscal calculations, underestimating the excess caseload would make the commitment too small and the windfall too large and vice versa. The fiscal calculations are not based on actual individual-level data on costs; if, for example, costs were substantially lower due to reductions in utilization during the pandemic, or if average adult costs are higher than the costs for pregnant women, this would lead to overestimation of both the windfall and commitment, with likely a larger overestimate for the commitment. The estimate also combines Medicaid and CHIP, while in practice they have different FMAP rates; CHIP has a higher rate, and since some of the Medicaid caseload would otherwise be in CHIP, this will likely underestimate the commitment. In our uninsurance estimates, we are assuming that caseloads will remain elevated due to higher than historical Medicaid take-up for some of the excess caseload; however, if the redetermination process does not go smoothly, for example, the state is understaffed in terms of caseworkers or technical problems arise from the sheer number of individuals the state will need to process, we will be underestimating coverage losses at least in the short run, as more than predicted will be eligible but unable to enroll. Finally, take-up rates used in the projections are based on the literature but may not apply to these specific populations at this point in time.

Conclusion

Policies to ensure ongoing access to health insurance during the public health emergency associated with the COVID-19 pandemic and support to state government finances have resulted in unprecedented increases in health insurance coverage in Texas and likely caused large declines in the uninsurance rate. These policies have also brought substantial federal subsidies to the state. With the end of the PHE, Medicaid's continuous coverage requirement will expire and eligibility redeterminations will begin. The potential for large-scale loss of coverage exists since some current members will be ineligible for benefits based on the state's pre-existing categorical and income eligibility rules and some will not successfully complete the redetermination process for other reasons. Texas eligibility rules ensure, for example,

that many of the formerly Medicaid-eligible pregnant women will be ineligible for subsidized coverage, since they will fall into the coverage gap between Medicaid parental eligibility and Marketplace subsidy eligibility. More generous and ongoing Marketplace subsidies have covered many more Texans as well, and could provide coverage to some who will lose Medicaid eligibility, but getting eligible people enrolled remains an ongoing challenge.

We estimate that currently more than 1,000,000 Texans are covered by Medicaid solely due to PHE policies. The majority are children and with large subgroups of low-income pregnant women and parents of dependent children. With the eventual end of the PHE, our conservative estimates suggest that 550,000 to 730,000 individuals will lose Medicaid/CHIP coverage. After accounting for potential enrollment in subsidized Marketplace coverage among those who might be eligible, we expect this to increase the uninsurance rate statewide by at least 2 percentage points, an increase of about 10%.

The PHE provided a large financial windfall for the state through Medicaid, which we estimate at \$3.5 billion in total, however, the state's growing commitment to fund higher than usual caseloads means the fiscal impacts are less favorable as time goes on. These findings suggest a tradeoff: the PHE provided large gains in coverage at a low cost to the state, however, maintaining the same level of Medicaid caseload after the PHE would increase the state costs for the Medicaid program by more than \$167 million per month. Of course, many individuals currently enrolled are likely to be found ineligible at redetermination; our estimates of projected ongoing enrollment post-PHE statewide suggest an increase of around \$40 million, almost all due to children's enrollment remaining higher than the historical average from a permanent shift in take-up by children who are eligible but might historically have remained unenrolled.

Federal legislative changes have also strongly increased Marketplace enrollment in Texas. Our estimates suggest that about 750,000 people enrolled due to the more generous subsidies. Given the recent federal guidelines that will resolve the "family glitch", we can expect growing enrollment in future years (at least until 2025 after which the increased subsidies are scheduled to expire).²⁹ Overall, we estimate that about 30% of the total number of Marketplace-eligible but uninsured individuals in 2020 had enrolled by 2022 in Texas, with large differences in Marketplace enrollment by county.

Recommendations

Texas has made historic gains in health insurance coverage, particularly for children in low-income families, as a result of new federal legislation affecting Medicaid and subsidized Marketplace eligibility. As the PHE ends and some of these policies expire, opportunities to maintain coverage for some affected individuals who might typically be hard to reach and connect to coverage exist. Attention to policies and administrative actions that support ongoing insurance enrollment can help ensure that the large gains to insurance coverage achieved during the PHE can be sustained.

To achieve the policy goal of maximizing insurance coverage, our results combined with existing literature suggest several recommendations.

First, children will be the largest group subject to Medicaid redetermination and the group driving the majority of the increase in uninsurance. In this group, enrollment had been trending downward prior to 2020 despite state population growth, likely in part due to policies that increased administrative burdens to families by requiring more frequent income reporting within a short time period; these policies instead could be altered to mirror what is required for CHIP.³⁰ State program administrators who are interested in minimizing disruptions to eligible children would pursue strategies that follow CMS guidance and are targeted toward supporting those who most likely remain eligible for subsidized coverage but who may struggle with Medicaid redetermination.³¹ The state's current plan³² focuses on prioritizing redeterminations for those most likely to be ineligible based on family status or age, and projects a tighter than required timeline, suggesting a goal of minimizing required state outlays after enhanced federal funds expire. However, staffing shortages and processing backlogs exist even prior to the end of the PHE.³³ With the onset of the large number of required redeterminations, the feasibility of a short redetermination timeline seems questionable, and can be expected to contribute to coverage losses if not remedied through aggressive hiring or outsourcing (for example, allowing Navigator programs as well as managed care organizations³⁴ to help); easing administrative burdens will also minimize required staff time. Contact information is likely to be out of date, creating additional concerns about allowing sufficient time for responses and outreach efforts. The state could also use verified information from its SNAP program or the unemployment insurance wage reporting system for many families to streamline processing. Administrative policies that reduce the red-tape induced costs of processing renewals and redeterminations will benefit the state, managed care plans, and low-income families.

Second, expanding Medicaid to those making less than 133% of the FPL could cover many adults including new mothers who would fall into the coverage gap, as well as many other adults who are currently uninsured because they do not qualify categorically; recent estimates suggest that nearly 1,000,000 people would be estimated to enroll with an annual cost to the state at approximately \$600 million without considering potential budgetary offsets which further reduce the cost.¹⁸ An expansion would be fully paid for without any offsets for the first several years under the 5% higher current federal match for two years on traditional populations, the most generous offer since the first several years of the ACA, when it was fully funded.³⁵

Finally, enhanced federal subsidies for Marketplace coverage remain available through at least 2025, and our data show that Marketplace take-up still has substantial room for growth. Many of the children and adults who are no longer eligible for Medicaid may qualify for Marketplace coverage, but the state's current presentations on the unwinding do not mention any strategies for encouraging those who are found ineligible but may be eligible for Marketplace coverage to seek

coverage there. The large differences in enrollment by county suggest that there is room for targeted outreach to increase enrollment, which has been shown to increase take-up; transitions may be limited to a relatively small fraction otherwise.^{36,37} Enrollment efforts should focus on counties with a large remaining number of uninsured individuals that are eligible for Marketplace coverage, but have so far not signed up. Navigator organizations in Texas have received significant federal funding to aid this effort.³⁸ Their effectiveness may be further enhanced through partnerships with the state targeted at individuals who were redetermined ineligible for Medicaid or failed to complete the process; the state could provide Navigators with their contact information directly, a process that is in place in several other states and would be parallel with the state's case affiliate program for managed care plans.³⁴

Additionally, progress has been made with Marketplace plan affordability in future years, especially in rural counties. The Texas Department of Insurance was granted the power of insurance rate review of Marketplace plans, with a specific goal to apply silver loading to Marketplace plans to increase the subsidy to health plans and decrease the out of pocket premium cost for purchased plans without any additional cost to the state.³⁹ Further, recently redrawn rating areas that will take effect in 2023 should improve affordability by improving the average risk pool for rural counties, who generally have high rates of uninsurance. Maximizing transitions to Marketplace would allow Texas to take advantage of momentum in health insurance coverage at no additional ongoing cost to the state.

Technical Appendix

In order to estimate the impact of MOE policies on Medicaid caseload, we considered two different models of Medicaid enrollment. Model 1 includes a time trend and fixed effects for month to adjust for seasonality in enrollment and long-term population trends, estimated on state-reported caseload data from 2014-2019⁴⁰, and projects these historic trends through 2022. The following formula describes the estimation approach using the historic data from which we extrapolate 2020-2022.

$$Y_t = \beta_1 Month_t + \delta_t + \varepsilon_t$$

Where Y_t is the aggregate monthly Medicaid caseload in month t . β_1 reflects the time trend and δ_t reflects a calendar month fixed effect to account for common seasonal shocks to enrollment. To account for serial autocorrelation, we include 12 lagged months in the model's standard errors. ε_t is the error term.

Model 2 includes the same elements in addition to a control for lagged unemployment rate that captures the relationship between Medicaid enrollment and the unemployment rate. We include this to incorporate the possibility that economic conditions may have driven some of the increase in enrollment which could be sustained over time – unemployment spiked during the early PHE and slowly recovered throughout. The model is displayed here.

$$Y_t = \beta_1 Month_t + \delta_t + Unemployment\ rate_{t-1} + \varepsilon_t$$

We estimate the models on both the aggregate state caseload data and on county-level caseload data, and generate counterfactual predictions of enrollment at the state and county level overall and by group.

For the impact of ARPA on Marketplace enrollment, we assume that any change in enrollment from the pre-policy period 2018-2020 average is due to the changes in ARPA subsidy. This should yield a fairly accurate prediction given that Marketplace enrollment trends remained flat from 2018 to 2020 in Texas.

Medicaid Coverage Transition

In our projections of post-PHE changes in uninsurance, we apply the 2019 household income distribution of Medicaid-enrolled children in Texas and calculate that 77% of the excess enrollment of children facing redetermination may still be eligible for Medicaid or CHIP coverage as their household income is likely below 200% FPL.⁴¹ This implies that up to 23% of children may be eligible for Marketplace coverage (assuming that their parents do not have access to affordable coverage). Based on recent literature, children's Medicaid take-up rates are about 75% in Medicaid⁴² and 33% in commercial coverage^{28,37} for newly ineligible Medicaid enrollees and thus we estimate that out of the 610,338 statewide excess children caseload only 211,543 will become uninsured. We perform a similar calculation for the 288,879 pregnant women excess caseload, where we expect a small share to be eligible under the

parents Medicaid program, a majority to be eligible for Marketplace coverage, and the remainder to fall into the coverage gap.⁴³ Finally, we assume that any excess enrollment not associated with these two eligibility groups will be uninsured after redetermination. This approach assumes that some portion of the excess Medicaid caseload will re-enroll in Medicaid coverage, implying that overall caseloads will be permanently higher than in the pre-PHE era and that take-up will remain higher than historical rates (consistent with woodwork or welcome mat effects commonly found with Medicaid expansions pre and post ACA, particularly for children).^{44,45}

Table 3. PHE Changes in Enrollment and Changes in Uninsurance after PHE

County	(1) Estimated Excess Enrollment Medicaid	(2) Estimated Excess Enrollment Marketplace	(3) Projected Change in Uninsured after PHE	(4) Projected Change in Uninsurance Rate after PHE	(5) Projected Change in Uninsured after PHE with 18% Medicaid Disenrollment Rate	(6) Projected Change in Uninsured Rate after PHE with 18% Medicaid Disenrollment Rate	(7) Remaining Uninsured Marketplace Eligible Individuals 2022
Overall Texas	1,029,421	753,718	567,708	1.96%	728,736	2.51%	1,723,168
Anderson	1,992	1,919	1,353	2.34%	1,895	3.28%	2,503
Andrews	624	464	463	2.48%	607	3.25%	1,126
Angelina	3,479	2,947	2,263	2.61%	3,594	4.14%	4,427
Aransas	632	510	495	2.11%	820	3.49%	1,401
Archer	0	348	115	1.34%	183	2.13%	376
*Armstrong							
Atascosa	2,757	704	1,704	3.33%	2,349	4.59%	3,718
Austin	662	601	605	2.02%	865	2.88%	1,918
Bailey	24	174	140	2.00%	308	4.40%	543
Bandera	458	391	410	1.78%	555	2.40%	1,624
Bastrop	5,877	2,182	3,334	3.76%	3,715	4.19%	5,385
Baylor	0	27	38	1.08%	130	3.70%	275
Bee	940	326	745	2.29%	1,218	3.74%	2,299
Bell	19,328	6,925	11,725	3.23%	13,380	3.69%	15,176
Bexar	73,713	38,182	47,110	2.35%	72,711	3.63%	125,872
Blanco	0	295	120	1.01%	205	1.72%	711
*Borden							
Bosque	340	276	349	1.87%	568	3.04%	1,288
Bowie	3,622	1,248	2,183	2.34%	3,729	4.00%	4,874
Brazoria	15,059	7,618	9,186	2.45%	10,352	2.77%	16,669
Brazos	7,529	3,559	4,765	2.08%	5,751	2.51%	8,457
Brewster	0	112	31	0.34%	181	1.97%	884
Briscoe							
Brooks	18	259	133	1.87%	474	6.68%	336
Brown	1,256	377	868	2.29%	1,419	3.75%	2,557
Burleson	370	297	324	1.76%	583	3.16%	895
Burnet	1,127	971	897	1.86%	1,292	2.68%	2,299
Caldwell	2,445	1,314	1,531	3.51%	1,913	4.38%	2,563
Calhoun	216	359	320	1.50%	741	3.48%	1,482
Callahan	232	336	323	2.32%	447	3.20%	702
Cameron	14,511	18,871	10,186	2.41%	24,363	5.76%	38,646
Camp	150	262	274	2.09%	587	4.48%	818
Carson	0	62	78	1.31%	108	1.83%	518
Cass	1,040	535	664	2.21%	1,173	3.91%	1,484
Castro	73	139	222	2.95%	330	4.38%	617
Chambers	1,763	1,748	1,087	2.48%	1,203	2.74%	1,791
Cherokee	2,052	938	1,383	2.63%	2,299	4.37%	3,701
Childress	0	107	55	0.75%	199	2.72%	561
Clay	86	270	193	1.85%	262	2.51%	586
Cochran	0	102	37	1.29%	136	4.78%	217
Coke	0	78	54	1.60%	95	2.79%	163
Coleman	6	124	143	1.75%	298	3.65%	553
Collin	29,075	29,394	18,075	1.75%	16,433	1.59%	18,733
Collingsworth	0	14	31	1.05%	104	3.58%	267
Colorado	473	732	437	2.03%	705	3.28%	1,108
Comal	5,319	3,924	3,394	2.17%	3,281	2.10%	3,671
Comanche	296	203	318	2.33%	511	3.75%	865
Concho	0	42	27	0.97%	84	3.08%	259
Cooke	1,315	860	908	2.20%	1,290	3.13%	2,550
Coryell	3,506	763	2,208	2.91%	2,252	2.97%	5,007
*Cottle							
Crane	20	206	110	2.29%	161	3.36%	268
Crockett	0	213	63	1.83%	117	3.38%	58
Crosby	0	153	126	2.20%	280	4.87%	458
Culberson	0	50	21	0.98%	98	4.52%	211
Dallam	181	143	214	2.93%	274	3.76%	490
Dallas	72,907	60,644	55,193	2.09%	96,092	3.65%	240,330
Dawson	222	207	236	1.85%	541	4.25%	810
DeWitt	393	353	351	1.74%	724	3.59%	1,127
Deaf Smith	440	221	458	2.47%	826	4.45%	1,608
Delta	0	66	99	1.85%	194	3.64%	360
Denton	23,657	19,385	15,341	1.73%	15,455	1.74%	24,858
Dickens	0	32	28	1.26%	60	2.70%	207
Dimmit	89	261	198	1.95%	577	5.70%	930
Donley	0	55	45	1.37%	93	2.84%	297
Duval	330	1,071	308	2.76%	628	5.63%	375
Eastland	422	301	395	2.15%	697	3.80%	1,128
Ector	8,343	7,645	4,699	2.83%	6,372	3.83%	6,308
*Edwards							
El Paso	26,073	24,593	19,415	2.31%	36,835	4.39%	65,959
Ellis	7,278	644	4,721	2.55%	5,184	2.80%	12,065
Erath	1,249	1,070	940	2.20%	1,150	2.69%	1,769
Falls	268	330	271	1.57%	654	3.78%	1,206
Fannin	961	603	671	1.89%	1,044	2.94%	2,413
Fayette	342	323	371	1.46%	615	2.43%	2,178
Fisher	0	46	64	1.67%	114	2.98%	255
Floyd	0	219	90	1.58%	253	4.43%	432
*Foard							

County	(1) Estimated Excess Enrollment Medicaid	(2) Estimated Excess Enrollment Marketplace	(3) Projected Change in Uninsured after PHE	(4) Projected Change in Uninsurance Rate after PHE	(5) Projected Change in Uninsured after PHE with 18% Medicaid Disenrollment Rate	(6) Projected Change in Uninsured Rate after PHE with 18% Marketplace Medicaid Disenrollment Rate	(7) Remaining Uninsured Marketplace Eligible Individuals 2022
Fort Bend	31,530	36,721	19,315	2.38%	19,105	2.35%	9,337
Franklin	187	304	264	2.46%	385	3.59%	561
Freestone	691	395	520	2.64%	684	3.47%	1,309
Frio	411	192	391	1.93%	836	4.12%	1,506
Gaines	1,282	386	885	4.12%	909	4.23%	1,500
Galveston	10,540	6,418	6,702	1.96%	9,519	2.78%	15,088
Garza	0	103	78	1.24%	177	2.84%	548
Gillespie	152	883	279	1.04%	543	2.01%	1,492
*Glasscock							
Goliad	0	147	97	1.26%	215	2.80%	384
Gonzales	621	313	577	2.77%	931	4.47%	1,147
Gray	739	533	595	2.72%	786	3.59%	1,595
Grayson	5,276	2,078	3,373	2.48%	4,321	3.17%	8,648
Gregg	5,552	3,089	3,623	2.92%	5,169	4.17%	7,263
Grimes	982	751	705	2.44%	1,009	3.49%	1,095
Guadalupe	5,855	1,526	3,736	2.24%	4,239	2.54%	7,791
Hale	815	510	730	2.19%	1,402	4.20%	3,115
Hall	0	92	22	0.76%	122	4.11%	225
Hamilton	68	116	182	2.15%	258	3.05%	533
Hansford	0	203	85	1.58%	145	2.68%	325
Hardeman	0	58	72	1.82%	143	3.62%	280
Hardin	1,768	479	1,194	2.07%	1,732	3.01%	3,630
Harris	185,214	157,706	120,688	2.56%	174,376	3.70%	333,190
Harrison	2,270	1,550	1,589	2.39%	2,582	3.88%	2,884
Hartley	0	18	37	0.67%	84	1.51%	562
Haskell	0	78	103	1.82%	195	3.44%	373
Hays	7,993	4,539	5,044	2.19%	5,090	2.21%	11,948
Hemphill	0	93	20	0.51%	79	2.07%	259
Henderson	3,817	1,217	2,308	2.79%	3,223	3.89%	4,718
Hidalgo	37,141	61,620	23,931	2.75%	52,019	5.99%	57,296
Hill	1,292	674	916	2.50%	1,335	3.64%	2,342
Hockley	700	460	535	2.32%	893	3.88%	1,837
Hood	1,981	1,431	1,406	2.28%	1,609	2.61%	2,408
Hopkins	1,178	743	924	2.49%	1,348	3.63%	2,110
Houston	436	429	370	1.61%	798	3.47%	1,363
Howard	829	432	613	1.67%	1,122	3.06%	2,130
Hudspeth	145	149	202	4.13%	237	4.85%	231
Hunt	4,746	1,048	2,954	3.00%	3,508	3.56%	5,427
Hutchinson	754	294	555	2.65%	681	3.25%	1,799
*Irion							
Jack	209	282	256	2.87%	287	3.22%	442
Jackson	326	121	332	2.25%	507	3.43%	920
Jasper	1,042	591	732	2.06%	1,410	3.97%	2,121
Jeff Davis	0	65	0	0.00%	32	1.39%	184
Jefferson	8,847	4,678	5,259	2.09%	10,126	4.03%	18,218
Jim Hogg	0	646	107	2.05%	304	5.84%	7
Jim Wells	1,956	847	1,256	3.10%	2,185	5.40%	2,537
Johnson	7,198	1,872	4,747	2.70%	5,541	3.15%	12,316
Jones	165	229	227	1.13%	519	2.58%	1,321
Karnes	237	142	241	1.54%	547	3.51%	950
Kaufman	10,427	8,071	5,995	4.40%	4,999	3.67%	115
Kendall	861	1,083	672	1.42%	748	1.58%	2,106
*Kenedy							
*Kent							
Kerr	1,164	1,111	973	1.85%	1,501	2.85%	3,627
Kimble	0	104	57	1.32%	141	3.26%	235
*King							
Kinney	0	68	31	0.84%	98	2.67%	369
Kleberg	1,047	414	730	2.38%	1,340	4.37%	2,239
Knox	0	40	69	1.88%	150	4.08%	246
La Salle	0	65	134	1.78%	310	4.12%	749
Lamar	1,611	1,866	1,096	2.20%	2,032	4.08%	2,174
Lamb	160	189	275	2.13%	581	4.51%	1,205
Lampasas	440	317	446	2.08%	638	2.98%	1,183
Lavaca	345	258	362	1.80%	573	2.84%	1,161
Lee	349	237	345	2.00%	552	3.20%	1,451
Leon	467	243	413	2.37%	560	3.22%	918
Liberty	9,952	3,071	4,975	5.64%	4,710	5.34%	4,555
Limestone	710	299	644	2.75%	962	4.11%	1,712
Lipscomb	0	93	36	1.13%	80	2.46%	224
Live Oak	96	176	190	1.56%	352	2.89%	1,245
Llano	522	248	426	1.95%	559	2.56%	1,225
*Loving							
Lubbock	11,753	6,981	7,577	2.44%	10,446	3.36%	12,390
Lynn	0	141	109	1.84%	210	3.52%	457
Madison	329	301	327	2.29%	499	3.49%	309
Marion	136	167	209	2.12%	415	4.21%	16,695
*Martin							
Mason	0	127	39	0.91%	90	2.11%	816

County	(1) Estimated Excess Enrollment Medicaid	(2) Estimated Excess Enrollment Marketplace	(3) Projected Change in Uninsured after PHE	(4) Projected Change in Uninsurance Rate after PHE	(5) Projected Change in Uninsured after PHE with 18% Medicaid Disenrollment Rate	(6) Projected Change in Uninsured Rate after PHE with 18% Medicaid Disenrollment Rate	(7) Remaining Uninsured Marketplace Eligible Individuals 2022
Matagorda	1,492	673	1,057	2.88%	1,578	4.31%	37
Maverick	3,520	4,655	2,109	3.59%	3,769	6.42%	0
McCulloch	95	90	186	2.34%	306	3.83%	204
McLennan	9,543	3,666	6,207	2.42%	9,267	3.61%	0
McMullen	0	28	0	0.00%	14	1.94%	6,424
Medina	1,637	986	1,105	2.14%	1,666	3.23%	3,550
Menard	0	25	22	1.01%	65	3.04%	141
Midland	6,793	5,371	3,813	2.16%	4,735	2.68%	6,779
Milam	594	397	537	2.16%	975	3.93%	1,324
Mills	0	77	76	1.56%	138	2.83%	301
Mitchell	0	80	122	1.43%	248	2.91%	642
Montague	448	302	397	2.00%	632	3.19%	1,278
Montgomery	26,738	17,200	15,816	2.60%	16,504	2.72%	25,163
Moore	494	346	453	2.17%	734	3.51%	1,729
Morris	395	274	373	3.01%	579	4.67%	772
*Motley							
Nacogdoches	2,071	947	1,476	2.26%	2,397	3.68%	4,526
Navarro	2,509	1,055	1,634	3.26%	2,371	4.73%	3,051
Newton	0	141	68	0.50%	420	3.09%	953
Nolan	186	171	253	1.72%	605	4.11%	1,003
Nueces	12,216	4,115	8,053	2.22%	14,226	3.93%	28,230
Ochiltree	98	367	208	2.12%	288	2.93%	600
Oldham	0	28	0	0.00%	62	2.95%	165
Orange	3,144	849	1,865	2.24%	3,100	3.72%	5,314
Palo Pinto	1,171	590	803	2.75%	1,076	3.68%	1,523
Panola	705	432	509	2.19%	819	3.53%	1,742
Parker	4,666	1,631	3,042	2.13%	3,225	2.26%	7,127
Parmer	16	58	154	1.60%	321	3.35%	909
Pecos	284	610	293	1.85%	546	3.45%	1,063
Polk	2,076	1,685	1,347	2.62%	1,947	3.79%	1,752
Potter	3,768	1,448	2,814	2.40%	5,233	4.46%	11,759
Presidio	0	531	7	0.10%	338	5.03%	311
Rains	224	27	276	2.20%	382	3.05%	929
Randall	4,819	799	3,050	2.22%	3,021	2.19%	5,162
Reagan	0	85	53	1.38%	111	2.88%	164
Real	0	45	57	1.64%	126	3.65%	352
Red River	211	339	230	1.92%	463	3.85%	707
Reeves	297	468	257	1.61%	532	3.33%	1,015
Refugio	0	95	122	1.75%	258	3.72%	514
*Robertson							
Robertson	464	85	413	2.42%	695	4.07%	1,066
Rockwall	3,337	2,006	2,034	1.94%	1,903	1.81%	3,876
Runnels	174	181	236	2.30%	372	3.63%	631
Rusk	2,041	556	1,332	2.45%	1,900	3.49%	4,317
Sabine	21	261	148	1.41%	360	3.41%	566
San Augusti..	0	410	71	0.86%	355	4.31%	266
San Jacinto	1,051	301	705	2.44%	1,083	3.75%	1,694
San Patricio	2,927	1,035	1,839	2.76%	2,917	4.37%	4,310
San Saba	0	98	66	1.08%	194	3.20%	375
Schleicher	0	41	26	0.94%	78	2.78%	215
Scurry	473	189	389	2.33%	583	3.49%	1,105
Shackelford	0	162	73	2.23%	100	3.07%	94
Shelby	749	551	583	2.31%	1,140	4.51%	1,379
Sherman	0	13	64	2.13%	85	2.80%	268
Smith	9,253	4,289	5,957	2.56%	8,007	3.44%	15,516
Somervell	51	156	167	1.83%	252	2.76%	485
Starr	2,750	8,074	1,662	2.57%	4,683	7.25%	0
Stephens	63	171	190	2.03%	341	3.65%	566
*Sterling							
*Stonewall							
Sutton	0	58	50	1.33%	103	2.72%	243
Swisher	0	248	116	1.57%	288	3.89%	491
Tarrant	75,757	36,199	50,365	2.40%	66,165	3.15%	143,358
Taylor	4,236	2,892	3,065	2.22%	4,758	3.45%	6,734
*Terrell							
Terry	273	295	277	2.24%	571	4.63%	967
*Throckmort..							
Titus	950	747	853	2.61%	1,418	4.33%	1,873
Tom Green	4,105	1,825	2,771	2.32%	3,777	3.17%	6,265
Travis	21,799	21,775	15,846	1.24%	27,427	2.15%	59,357
Trinity	356	417	351	2.40%	592	4.04%	688
Tyler	785	349	584	2.70%	780	3.60%	1,305
Upshur	1,729	951	1,145	2.74%	1,557	3.73%	1,703
Upton	0	94	30	0.82%	113	3.10%	155
Uvalde	825	668	667	2.49%	1,320	4.94%	2,469
Val Verde	1,571	1,820	987	2.01%	2,353	4.80%	3,997
Van Zandt	2,180	666	1,466	2.59%	1,885	3.33%	3,920
Victoria	3,511	1,355	2,260	2.45%	3,511	3.81%	6,103
Walker	1,865	2,171	1,403	1.92%	1,726	2.37%	2,964

County	(1) Estimated Excess Enrollment Medicaid	(2) Estimated Excess Enrollment Marketplace	(3) Projected Change in Uninsured after PHE	(4) Projected Change in Uninsurance Rate after PHE	(5) Projected Change in Uninsured after PHE with 18% Medicaid Disenrollment Rate	(6) Projected Change in Uninsured Rate after PHE with 18% Medicaid Disenrollment Rate	(7) Remaining Uninsured Marketplace Eligible Individuals 2022
Waller	2,144	3,982	1,484	2.69%	1,805	3.27%	0
Ward	192	327	226	1.88%	409	3.41%	824
Washington	764	206	613	1.71%	1,000	2.79%	2,137
Webb	10,228	11,678	6,931	2.51%	15,791	5.71%	26,907
Wharton	1,410	957	1,017	2.45%	1,684	4.05%	2,694
Wheeler	0	52	95	1.88%	155	3.06%	458
Wichita	4,464	2,495	3,036	2.30%	4,565	3.45%	5,190
Wilbarger	327	179	392	3.07%	545	4.27%	907
Willacy	227	806	308	1.44%	1,134	5.31%	1,031
Williamson	16,180	11,942	10,623	1.80%	10,561	1.79%	14,733
Wilson	1,357	809	943	1.85%	1,250	2.45%	2,366
Winkler	0	430	57	0.71%	257	3.20%	341
Wise	2,324	657	1,565	2.24%	1,864	2.66%	4,083
Wood	1,455	716	1,053	2.31%	1,374	3.02%	2,945
Yoakum	251	336	249	2.86%	307	3.53%	447
Young	356	389	389	2.16%	646	3.59%	1,095
Zapata	404	1,415	377	2.66%	875	6.17%	300
Zavala	207	238	269	2.27%	716	6.05%	1,152

Notes: Counties with missing data had population counts with less than 2000 residents that did not allow for an estimation of changes in enrollment, indicated with *. Source: Authors' calculations from American Community Survey, Texas DHHS, CMS, and Texas Workforce Commission data.

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