Projected Uninsurance Increases from the End of Federal Health Insurance Marketplace Subsidies in Texas

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Texas A&M University

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Executive Summary:

Texas has seen important reductions in uninsurance since the implementation of the Patient Protection and Affordable Care Act, driven by enrollment in subsidized Marketplace plans. At the end of 2025, subsidies that have made this coverage more affordable for millions since 2021 are set to expire. In this brief, we discuss the important role Marketplace plays in the Texas health insurance market. A large population, high uninsured rate, and heavy reliance on Marketplace coverage mean that subsidy expiration could reverse years of progress in expanding health insurance coverage, potentially leaving hundreds of thousands of Texans without affordable coverage options and creating increased financial instability for the state's healthcare system. Our estimates suggest that between 665,000 and 1.45 million Marketplace enrollees will not continue individual Marketplace coverage in Texas in 2026, representing declines of 17-37% from 2025. These losses in Marketplace coverage translate to up to 797,747 newly uninsured people, implying increases in the uninsurance rate for nonelderly Texans of 1.5-3.2 percentage points.

I. Introduction

Large and important gains have been made in reducing uninsurance in Texas since the implementation of the Patient Protection and Affordable Care Act (ACA, commonly known as Obamacare) in 2014. In 2013, 5.7 million Texans, 24.6% of the population under age 65, were living without health insurance.[i] While Texas remains the last-ranked state in uninsurance, recent data show the number uninsured among the nonelderly had been reduced to 4.8 million (18.5%) despite significant population growth over the same period.[ii] This progress has been driven largely by the ACA Marketplace,[iii] with almost 4 million Texans selecting a plan during the 2025 Open Enrollment Period (OEP)—a dramatic increase from the approximately 730,000 who enrolled during the first year of Marketplace operations in 2014.[2] Texas relies heavily on the ACA Marketplace compared to other states: 16% of Marketplace enrollees nationwide are Texans, making it the largest by enrollment volume, with nearly twice as many enrollees as next-largest Florida, while representing only 9% of the national population, meaning Texans are enrolled at nearly twice the rate expected based on population alone.[3]

Marketplace was envisioned as a way to provide easy to compare, affordable health insurance options for individuals and families who do not have access to employer-sponsored coverage or public programs like Medicaid. Premium subsidies were originally available for those with incomes 100-400% FPL, with larger subsidies for the lower-income.[iv] In 2021, Marketplace subsidies were temporarily expanded for the first time to people with incomes over 400% of the federal poverty level (FPL) and increased for those with lower incomes, resulting in large declines in the out-of-pocket price of health insurance premiums and increases in enrollment. Without further congressional action, premium tax credits will revert to their original, less generous structure beginning in 2026. This means that millions of Americans will face dramatic premium increases, with middle-income earners above 400% FPL losing all federal assistance

[i] Source: American Community Survey Tables for Health Insurance Coverage: Table HI-05: 2013

[ii] Source: Authors' calculations from the 2023 American Community Survey; reflects uninsurance among the civilian noninstitutionalized population under age 65.

[iii] Unlike 40 other states and the District of Columbia, Texas has not extended Medicaid coverage to adults earning up to 138% of the Federal Poverty Level, leaving a substantial coverage gap for low-income residents who earn too much for traditional Medicaid but too little to qualify for Marketplace subsidies. This issue is not the focus of our analysis, but is discussed further in Dague and Hughes (2020).[1]

[iv] 100%-400% FPL was $15,060-$60,240 for an individual or $31,200-$124,800 for a family of four in 2024

entirely. With open enrollment beginning November 1, 2025, plans are already releasing expected premiums and the window for addressing this issue is closing.

The expiration of enhanced Marketplace subsidies could result in several key consequences for Texans. First, many individuals who currently benefit from subsidies would face higher out-of-pocket premium costs. Estimates suggest that out-of-pocket premiums could increase in Texas by at least 115% or $456 based on 2024 premiums, with lower-income enrollees facing the steepest relative increases, potentially creating financial strain that may lead families to reduce spending on other necessities or forgo medical care.[4,5] Second, increased prices might make plans unaffordable for some consumers, who might purchase lower coverage plans or instead go uninsured. Research consistently demonstrates that even modest premium increases can lead to substantial coverage losses in low-income populations.[6–8] The economic impact of the expiration of these subsidies would reduce federal spending while increasing the financial burden on individuals, families, and health care providers, particularly in states like Texas which rely more heavily on private insurance markets than states that have participated in the ACA Medicaid expansions. With half of Texans reporting difficulty affording health care in a recent survey,[9] the expiration of these subsidies will worsen this affordability crisis, likely driving Texas's nation-leading uninsured rate even higher and increasing the burden of uncompensated care on the state's providers.

In this brief, we discuss the implications of subsidy expiration 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 use economic and statistical modeling tools to provide projected potential coverage losses due to these policies in addition to spillover consequences to hospitals. We project estimates to the county level as well as summarizing the state-level impact.

The bottom line: Texas's large population, high uninsured rate, and heavy reliance on Marketplace coverage mean that subsidy expiration could reverse years of progress in expanding health insurance coverage, potentially leaving hundreds of thousands of Texans without affordable coverage options and creating increased financial instability for the state's healthcare system.

II. Background on Uninsurance and Marketplace in Texas

Uninsurance rates in Texas have consistently been higher than national averages and among the highest across all states. In the early 2000s, preceding the passage of the ACA, rates averaged 23-25%.[v] Despite significant progress over the last 15 years, uninsurance remains highly prevalent. This phenomenon does not solely relate to a lack of financial support or availability of programs, but also low participation in existing programs designed to increase access. Contributing factors may include the prevalence of low-wage jobs in industries that do not traditionally offer health insurance benefits, low awareness of the availability of subsidies and assistance, concerns about eligibility for help such as immigration status, or personal beliefs about the value of coverage. For example, although the coverage gap created by lack of opting in to the ACA's Medicaid expansion is real, it has been estimated to solve just 15% of uninsurance without additional shifts in take-up of existing programs.[10] Put differently, uninsurance rates with a Medicaid expansion might only decrease by 2-3 percentage points, implying Texas would remain in last place.

State policymakers' decision not to participate in Medicaid expansion has meant that almost all coverage growth has happened through changes in the non-group insurance market, particularly Marketplace (Healthcare.gov) coverage.[11] The Marketplace works by providing a centralized place for individuals to purchase private health insurance coverage, facilitating comparisons across plans, and incorporating individual subsidies for those with incomes 100-400% FPL into premium prices (until 2020). Subsidies are tied to the premium cost of the second cheapest benchmark Silver plan available to consumers in a market. Dramatic growth in this market has occurred over time, as shown in Figure 1, which shows total enrollment and the average subsidized out-of-pocket premium in Texas compared to the U.S. as a whole. Since 2021, Texas enrollment has risen sharply, while average subsidized premiums have fallen more steeply in Texas than nationwide. Today, the total number of Texas Marketplace enrollees (4 million, the majority of whom are adults) is almost equivalent to state Medicaid caseloads (4.1 million, the majority of whom are children).[12]

[v] Source: Authors' calculations from Census Bureau Current Population Survey, https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-hi.html

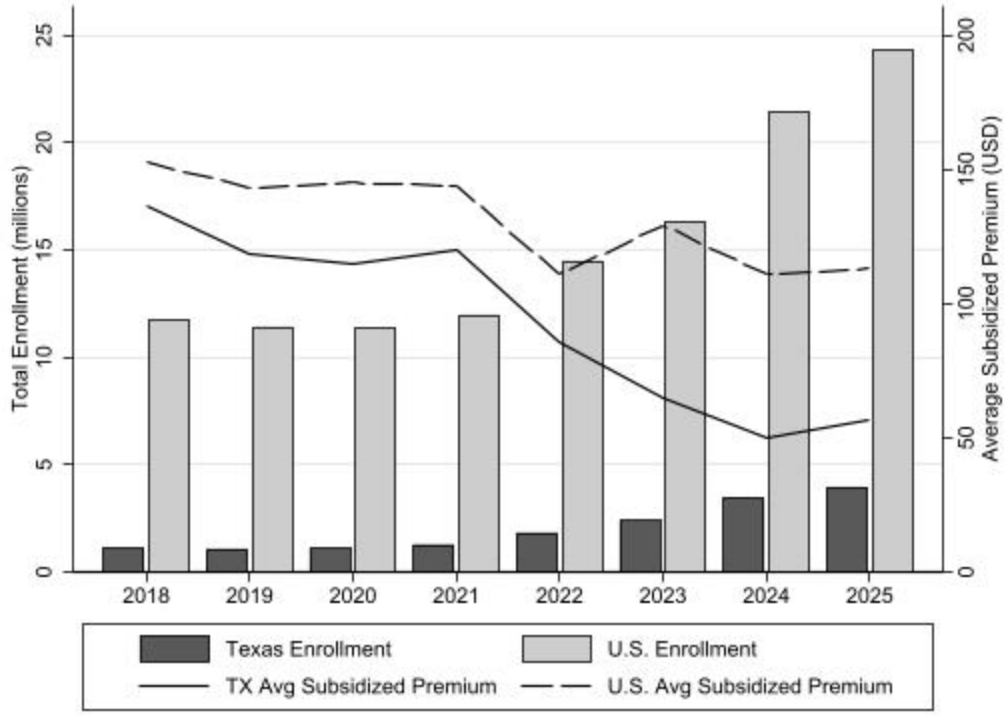

Figure 1. Marketplace Enrollment and Premiums in Texas and US. Source: OEP State-Level Public Use File (2018-2025)

The growth in Texas has been disproportionate – Figure 2 illustrates the growing share of Marketplace enrollment represented by Texans. Since 2018, the share of national enrollment made up of Texans has increased from 9.6% to 16.3%, an increase of nearly 70%; much of this increase occurred after 2021. Total enhanced subsidy value is estimated at more than $1.5 billion in Texas in 2024.[4]

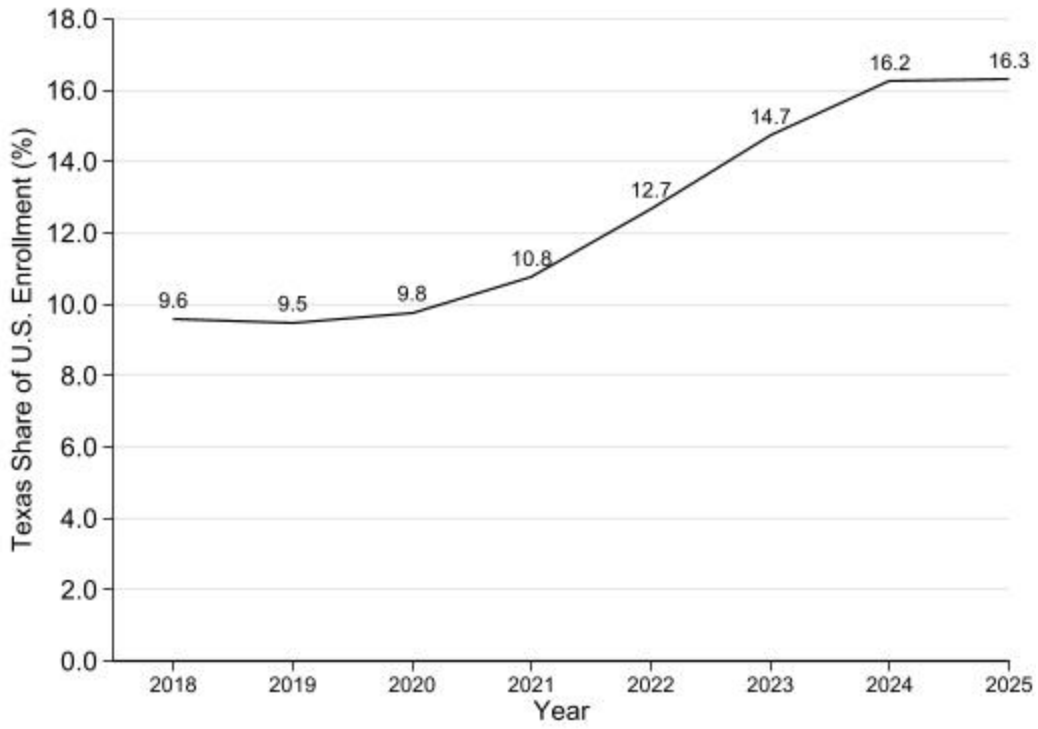

Figure 2. Texas Share of Total Marketplace Enrollment, 2018-2025. Source: OEP State-Level Public Use File (2018-2025)

Federal and state policy factors have driven this growth; a timeline describing the most relevant policy history for Marketplace is included as Figure 3.[13–19] The first major policy change following implementation was in 2017, when the federal government terminated direct payments to insurers for cost-sharing reduction (CSR) subsidies in 2017, resulting in insurers required to absorb those costs. Insurers responded by raising Silver plan premiums, known as "Silver-loading".[20] Full-price Silver plans became more expensive relative to Bronze and Gold plans, but premium subsidies increased (since they are based on the second cheapest Silver plan cost), making Gold or Bronze plans comparatively more attractive and often enabling zero-premium Bronze plans for subsidized consumers.[21–23] Some states, including Texas, responded to increased premiums with rate review policies that required firms to publicly justify certain pricing changes.

The American Rescue Plan Act (ARPA), signed into law in March 2021, introduced a major change to the Marketplace by dramatically expanding premium tax credits.[24] These enhanced subsidies increased the value of premium tax credits for existing beneficiaries while extending eligibility to middle-income Americans who previously

earned too much to qualify for assistance. Specifically, ARPA eliminated the "subsidy cliff" that had cut off premium assistance for individuals earning more than 400% of the Federal Poverty Level (approximately $62,600 for an individual in 2025), instead capping premium contributions at 8.5% of income regardless of earnings. The legislation also increased subsidy amounts for lower-income enrollees, with those earning 150-200% of FPL seeing their required premium contributions drop from up to 6.5% of income to just 2-4%, and individuals below 150% of the FPL having the subsidy covering the full premium. The Inflation Reduction Act (IRA) extended these subsidies, which had been set to expire in 2022, through 2025.[25] Without further action by policymakers, the subsidy schedule will return to pre-ARPA levels effective in January 2026; open enrollment for 2026 beginning in November 2025 will reflect higher out-of-pocket premiums across all income levels.

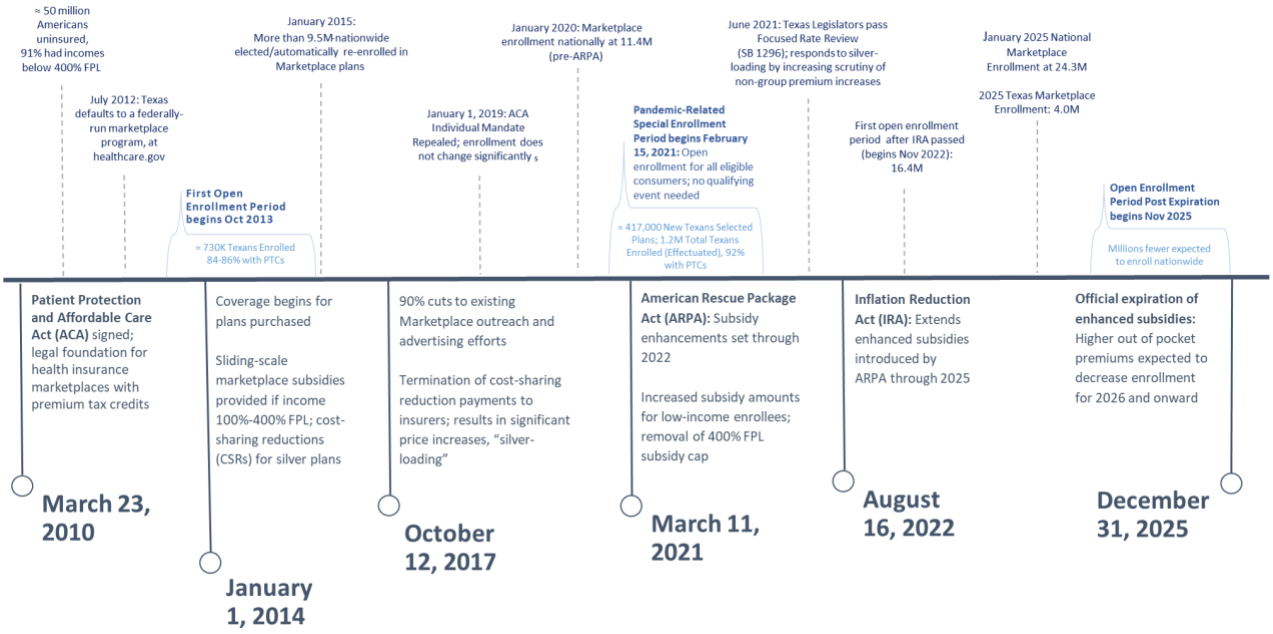

Figure 3. Marketplace Policy Milestone Timeline

High premiums and premium growth have been a consistent concern for the affordability of health insurance. The early years of the individual Marketplace saw substantial rate increases by insurance companies due to unforeseen high medical expenses, partially due to a sicker enrolled population than anticipated. For example, medical loss ratios, depicting the relationship between total paid medical services by insurance relative to the insurance premium, were close to and sometimes greater than 100% between 2014 and 2016.[26] Subsequently, a number of insurance companies exited

the individual Marketplace, with notable exits by UnitedHealth and Aetna in some states, while other insurers chose to increase premiums by as much as 145% in some markets for the second lowest cost Silver plan from 2016 to 2017 alone.[27] Congress tied the level of premium subsidies to the premium of second lowest cost Silver plan in markets. As such, increases in premiums increase the subsidy for enrollees, but out-of-pocket premium contributions are limited to the maximum allowable range of 2 to 9.8% of household income, which provides some protection from rising premiums for those receiving subsidies. The role of the enhanced premiums enacted in 2020 additionally reduced the maximum out-of-pocket premium, insulating enrollees further from premium levels and growth in premiums.

To illustrate the expected change in the level of out-of-pocket cost by income, we display an example using national estimates for the second cheapest Silver plan in Table 2. Here we focus on the impact on out-of-pocket premium costs for a 45-year-old single adult in 2025 and 2026. For 2026, we assume that rates will increase by 20%, the average proposed increase across current rate filings[vi] from the 15 Texas insurers.[28] With the enhanced premium tax subsidy available in 2025, out-of-pocket premium costs for a Silver plan are capped at $0 up to 150% of FPL or $23,475, and the subsidy would be $561 per month (the full premium). Those with incomes in the 150-200% FPL range are required to pay a maximum of $22 per month, (for a subsidy of $539). Premium costs rise moderately with income, with a contribution of $173 per month with income 250-300% FPL and $480 per month for incomes at 400% or higher ($62,600+).

[vi] Additional market and regulatory drivers may increase out-of-pocket premiums stemming from new pricing strategies, as discussed in the reference. While medical inflation and innovation tend to increase pre-subsidy premiums, they also constrain out-of-pocket premiums by increasing the available subsidy. However, new federal rules on the length of open enrollment and eligibility redeterminations could contribute to further increases in out-of-pocket premiums if they increase adverse selection, with younger and healthier individuals exiting Marketplace. As such, plan choice may be constrained, leading to larger out-of-pocket costs if insurers respond by reducing the actuarial value of plans through increasing cost-sharing provisions. However, this is out of the scope of this analysis; we take premium projections as given and assume rate filings reflect current market conditions.

Income (% of FPL)	Enhanced PTCs (until 2025)	Maximum Monthly out of pocket premium (2025)	Average silver plan premium (2025)	Enhanced PTC's Expire (starting 2026)	Expected maximum monthly out of pocket premium (2026)	Expected average silver plan premium (2026)
<138	0	0	$561	2.1	$33	$673
138-150	0	0	$561	3.10-4.19	$68	$673
150-200	0-2	$22	$561	4.19-6.6	$123	$673
200-250	2.0-4.0	$85	$561	6.6-8.44	$221	$673
250-300	4.0-6.0	$173	$561	8.44-9.96	$330	$673
300-400	6.0-8.5	$318	$561	9.96	$455	$673
400+	8.5	$480	$561	N/A	$673	$673

Table 2. Subsidy Schedule. Calculated for 45-year-old single adult; 100% FPL in 2025 was $15,650 per year. The out-of-pocket premium reflects what the individual is responsible for; the out-of-pocket premium plus the federal subsidy equals the full premium (price) of the plan. We assume that the average Silver plan premium will increase by 20% based on Texas rate filings for 2026.

The enhanced premium subsidies were, however, temporary, and current law dictates that out-of-pocket cost contributions will return to 2019 rates. A major driver of the reduction in average out-of-pocket premium was the broad availability of $0 Silver plans. Without the enhanced subsidies in 2026, expected premium contributions increase for all income groups, with premium contributions of $33 per month for those with less than 138% FPL and $68 per month for those with 138% to 150% FPL. For an individual with 250-300% FPL the premium contribution is $330 per month, a 90% increase relative to 2025, while income of 300-400% FPL would lead to $455 per month in premium contribution (a 43% increase).

Another important consideration is the subsidy cliff. Current policy provides subsidies for all households. Reverting to the previous subsidy schedule will eliminate subsidy eligibility for households making more than 400% of FPL, who would need to pay the full premium cost of $673 per month. Consequently, these households are likely to disenroll. For example, national enrollment in this income group was 1.7 million in 2025 (~125,000 in Texas), but only ~350,000 nationally in 2020 when not subsidy-eligible. Table 2 shows that the expected monthly out-of-pocket premium spikes by about 40% or nearly $200 per month for a Silver plan in this part of the income distribution.

To better understand the characteristics of Texans by insurance status, we used data from the American Community Survey (ACS). Table 3 summarizes demographic characteristics of Texans under age 65 according to their insurance status in 2023, the most current ACS data available. Overall, 18.5% of Texans under the age of 65 were uninsured, 53.0% had employer-sponsored insurance, 11.1% purchased private non-

group coverage, and 17.4% relied on public or other sources. The uninsurance rate for men was slightly higher at 19%, compared to 18% for women. The uninsurance rate is lowest for children, aged 0-18, at 12%. Young adults aged 19–34 are most likely to be uninsured, with an uninsurance rate of 26%. The rate generally declines with age thereafter; for adults aged 55–64, the uninsurance rate is 15%, the lowest among adult groups. The rate of non-group coverage increases with age, as the 17% rate for adults aged 55-64 is more than double the 8% rate for children.

Income is also strongly correlated with uninsurance. The uninsurance rate is highest for those with the lowest incomes, at 30% for Texans with incomes below 100% of the FPL and 30% for those in the 101–150% FPL bracket. The rate then steadily declines as income rises, dropping to 18% for those in the 301–400% FPL bracket. In sharp contrast, only 8% of those with incomes above 400% of the FPL are uninsured. In sharp contrast, only 8% of those with incomes above 400% of the FPL are uninsured. Conversely, the reliance on public coverage is highest for those with incomes below 100% FPL, at 44%, and falls dramatically as income increases. Race and ethnicity are also strongly correlated with insurance coverage. The uninsurance rate is highest among those reporting Hispanic origin at 27%. The Non-Hispanic Black population has the second-highest rate at 15%, followed by non-Hispanic White at 11% and non-Hispanic Asian at 7%. For non-group insurance purchases, the rate for non-Hispanic Asians is 22%, substantially higher than the approximate 11% for other groups. The uninsurance rate for non-citizens is much higher at 49%, compared to 14% for citizens by birth and 18% for naturalized citizens. Education is also strongly correlated with uninsurance. Texans with less than a high school education have an uninsurance rate of 35%, while only 8% of those with a bachelor's degree or higher are uninsured. Employment status is also strongly correlated with coverage. While the uninsurance rate for employed individuals is 19%, it is 41% for unemployed adults. The rate for students is 20%, while those not in the labor force for other reasons have an uninsurance rate of 26%.

	Uninsured	Private, ESI	Private, Nongroup	Public/Other	Total (weighted N)
TOTAL	18.5%	53.0%	11.1%	17.4%	25,805,206
Sex					
Male	19%	53%	11%	17%	12,952,544
Female	18%	53%	11%	18%	12,852,662
					25,805,206
Age					
Age 0–18	12%	45%	8%	35%	7,903,146
Age 19–34	26%	53%	11%	10%	6,644,552
Age 35–44	22%	59%	11%	8%	4,270,948
Age 45–54	19%	61%	13%	8%	3,691,568
Age 55–64	15%	56%	17%	13%	3,294,992
Income (FPL)					
Income <=100% FPL	30%	16%	10%	44%	3,269,717
Income 101-150% FPL	30%	22%	10%	38%	2,154,527
Income 151-200% FPL	28%	33%	13%	26%	2,314,710
Income 201-250% FPL	25%	44%	12%	19%	2,188,061
Income 251-300% FPL	22%	51%	13%	14%	2,148,890
Income 301-400% FPL	18%	60%	12%	11%	3,738,725
Income >400% FPL	8%	77%	10%	5%	9,954,433
Missing/NIU (poverty)	24%	9%	6%	60%	36,143
Race / Ethnicity					
NH White	11%	66%	12%	11%	9,168,127
NH Black	15%	51%	11%	24%	3,136,470
Hispanic	27%	40%	10%	22%	10,958,705
NH Asian (incl. NHPI)	7%	67%	22%	4%	202,239
NH Other/Multiple	11%	62%	14%	13%	2,339,665
Education					
Less than HS	35%	34%	11%	20%	3,633,191
High school	29%	46%	11%	14%	4,750,907
Some college/AA	19%	58%	13%	10%	5,336,829
BA or higher	8%	75%	13%	4%	5,905,297
Missing/NIU (education)	11%	45%	7%	37%	6,178,982
Citizenship					
Citizen by birth	14%	56%	10%	20%	21,161,178
Naturalized citizen	18%	57%	17%	8%	1,789,519
Non-citizen	49%	31%	13%	7%	2,854,509
Employment status (16+)					
Employed	19%	64%	12%	6%	14,119,464
Unemployed	41%	27%	14%	18%	638,909
NILF - Student (college/grad)	20%	45%	19%	17%	481,292
NILF - Other	26%	34%	14%	26%	3,924,775
Children (<16) or Missing/NIU	11%	45%	7%	37%	6,640,766

Table 3. Characteristics of Texans by Insurance Status. Source: Authors' calculations from the 2023 American Community Survey, reflecting civilian noninstitutionalized population ages 0-64.

We also summarized the characteristics of 2025 Marketplace adult enrollees using the Centers for Medicare & Medicaid Services (CMS) open enrollment files in Table 4. The first column displays characteristics of enrollees in the average county – equally weighting all counties – while the second column weights the data by the number of

enrollees in each county to display the characteristics of the average enrolled-Texan. Overall, the average Texas county had 15,615 Marketplace enrollees. Marketplace enrollees in Texas are fairly evenly distributed across the age distribution when weighted by enrollment. Approximately 53% are female, 18% are reported to be Hispanic, and 12% reported as non-Hispanic White; however, the majority are of unknown race, reflecting the limitations of the public data. The largest share of enrollees (62%) had incomes below 150% FPL, and 86% of all enrollees had incomes below 250% FPL, thereby enjoying substantial premium subsidies to lower the out-of-pocket cost of health insurance. As shown in Figure 1, average premium costs in Texas have historically been moderate compared to some states, but the large rural geography and concentration of providers in urban areas creates significant disparities in both cost and access across different regions of the state. Across plans, the average total premium was $573, driven in part by a large share of individuals choosing more expensive gold plans (35%), with an average monthly out-of-pocket payment of $57. However, many enrollees enjoyed a very low monthly out-of-pocket premium, with 58% enrolled in a health plan with a monthly out-of-pocket premium below $10 and 95% of enrollees receiving a subsidy.

	2025	2025 [Enrollment weighted]
Average Enrollment	15,615	
Age 26-34	14	16
Age 35-44	19	19
Age 45-54	19	18
Age 55-64	23	18
Female	53	53
Hispanic	14	18
White, Non-Hispanic	19	12
Unknown Race	61	59
FPL 100-150%	60	62
FPL 150-200%	15	15
FPL 200-250%	11	9
FPL 250-300%	6	5
FPL 300-400%	5	4
Plan Characteristics		
Silver	44	47
Gold	41	35
Average Premium	$659	$573
Premium after APTC	$59	$57
≤$10	62	58
Share receiving APTC	96	95

Table 4. County Level Marketplace Enrollee Characteristics. Sociodemographic characteristics are not available for all counties due to suppression rules by CMS; this means that totals may not sum to 100%. First column is representative of the average county report; second column is weighted by total county enrollment.

III. Data & Methods

To assess the potential impact of enhanced subsidy expiration on Texas Marketplace enrollment, we analyzed multiple data sources using established econometric methods to estimate premium elasticities and project coverage losses. This approach, described in detail below, allows us to identify not only the overall magnitude of potential coverage losses but also the specific communities and healthcare systems most vulnerable to subsidy expiration. We abstract from issues of plan participation and quality.[vii]

[vii] The Texas Marketplace typically features 10 or more insurance carriers statewide, though rural areas historically often had more limited plan options. Reduction in market size due to increased out-of-pocket premiums is likely to reduce plan participation and reduce the actuarial value of plans selected.

To estimate the elasticity of enrollment to out-of-pocket premiums, we used the Texas Marketplace Open Enrollment County-Level Public Use Files (PUF) from 2018-2025, which are published by CMS annually. These files include county-level information on total Marketplace enrollment and enrollment by plan type and sociodemographic profile. Plan characteristics include metal plan level, county-level average monthly gross premiums (before any subsidy) and net average premiums after advanced premium tax credits (APTC). County enrollment by characteristics of enrollees, including age, sex, self-reported race and ethnicity, and household income as a percent of the federal poverty level (FPL) is also reported.

A limitation is that enrollment for counties with few Marketplace enrollees is suppressed. Data elements are not reported for cells of fewer than 11 enrollees in a given year. However, most counties report the key variables for our study: enrollment and average net premiums in most years. For example, we observed total plan enrollment information for all 254 Texas counties in 2025, including all 82 metropolitan counties and 172 of the non-metropolitan counties.[viii] However, enrollee characteristics are missing more frequently. For this study, we include counties reporting enrollment and enrollee characteristics for at least 2 years and do not restrict to only include counties who are observed for all years. In subsequent robustness checks, we relax these restrictions.

Our empirical approach is to estimate the price elasticity of demand for health insurance using two key variables (enrollment and average net premium). Since counties vary in population size, we standardized Marketplace enrollment by dividing by the county-level 18- to 64-year-old county population obtained from the 2019 5-year American Community Survey estimates. To account for county-level differences, we create several variables from the CMS PUF Files to serve as control variables, including the share of enrollees in Silver plans, the share of individuals with incomes between 150-200, 200-250, 250-300, and 300-400 percent of the federal poverty limit, the share male, the share white, and the share of individuals with a plan aged 26-34, 35-44, 45-54, and 55-64 years old.

We explored multiple potential modeling approaches, including both cross-sectional (comparing across counties in the same year, treating variation in prices across counties

[viii] Metropolitan status is defined according to the United States Department of Agriculture's 2023 Rural-Urban Continuum Codes available at https://www.ers.usda.gov/data-products/rural-urban-continuum-codes

as exogenous) and panel (comparing enrollment in the same counties over time, treating variation in prices within counties as exogenous). Results were not particularly sensitive to specification, so we focus on the panel results here, estimating the following regression using all years of enrollment data from 2018 to 2024:

$$\log enrollment_{ct} = \beta_1 \log OOP\ premium_{ct} + \gamma_c + \rho_t + X_{ct} + \varepsilon_{ct} \quad (1)$$

Here, $\log enrollment_{ct}$ is the log per capita number of Marketplace enrollees in year t and county c standardized by the ACS county population. The independent variable of interest, $\log OOP\ premium_{ct}$, is the log of the out-of-pocket premium accounting for the advanced premium tax credit in county c and year t. We include γ_c, a county fixed effect and ρ_t, a year fixed effect. Including county fixed effects adjusts the regression to isolate the relationship between enrollment and out-of-pocket premiums across time within the same county. We include year fixed effects to account for annual shocks that affect all counties. X_{ct} is a vector of control variables based on the demographic and plan selection of individuals described above and ε_{ct} is the error term. We cluster standard errors at the county.

The above model informs our estimate of the relationship between out-of-pocket premiums and enrollment using the elasticity framework. Our estimated β_1 coefficient of −0.146 suggests relatively inelastic demand, suggesting that a 10% increase in out-of-pocket premiums decreases enrollment by 1.46%. We tested the robustness of the estimated regression coefficient by estimating equation (1) without demographic and plan controls to compare the variability of the estimate to the inclusion of different control variables, finding a larger but still inelastic price elasticity of -0.318 when excluding controls. Another benefit of this exercise is that this allows us to model enrollment responses due to expected premium increases using a distribution of elasticity estimates.

To project expected changes in county-level Marketplace enrollment in 2026, with the expiration of the enhanced premium tax credits in 2025, we utilize regression results from equation (1), where we use the 2025 Marketplace enrollment as baseline and generate the expected change in enrollment due to subsidy expiration using the elasticity estimate. Our estimate of the expected change in premium comes from KFF, who estimate that the out-of-pocket insurance premiums will increase by 115% in Texas.[4] To provide a broader range of expected projections, we perform several sensitivity analyses. First, we vary the elasticity by relying on estimates from equation (1)

without control variables. Second, we vary the expected change in premium increase and illustrate projected changes in enrollment if out-of-pocket premium increase were 50% and 150%.

Marketplace coverage exit may not lead to uninsurance, as individuals may qualify for Medicaid or commercial insurance coverage. To understand the extent of coverage loss translating to uninsurance, we utilize evidence from the literature that estimates insurance coverage loss. Unlike in states with a Medicaid expansion, Medicaid is not likely to be an option for many of those exiting Marketplace coverage in Texas. Therefore, we rely on estimates on pass-through of Marketplace loss to uninsurance from the Urban Institute that estimated that about 55% of those disenrolled from Marketplace will lose health coverage.[29] These estimates are in line with the average rate of uninsurance after exit from the Marketplace for any reason (more than 65% at 6 months; 45% at 12 months) in national survey data from 2019.[30]

We then proceed by estimating the predicted overall and county-level uninsurance rate in Texas . While the above allows us to create estimates of changes in uninsured due to increased premiums in the ACA Marketplace, estimates of the projected rate of uninsurance in the county and state requires a few additional assumptions. The latest year that uninsurance estimates for Texas from the ACS are available is currently 2023. However, we know that the Marketplace population has grown by approximately 1.5 million people in Texas from 2023 to 2025. As such, any 2023 uninsurance rate estimates are likely larger than we would expect in 2025, as the insurance rate has likely increased with the growth in Marketplace coverage in the last 2 years. To project 2025 uninsurance rates for the state and counties, we therefore assume that the growth in Marketplace coverage reduced the uninsured rolls from the 2023 levels by 0.55 for each 1 additional Marketplace enrollee from 2023 to 2025 (applying the pass-through estimate discussed above). This is imperfect, since there has also been population growth, and more people than typical may have been switching insurance products from Medicaid to Marketplace coverage because of the pandemic-era continuous enrollment rules that ended during that period.[31] This means that the 1.5 million new Marketplace enrollees reduced uninsurance by ~825,000 to generate the estimated 2025 uninsurance rates that we use as a baseline for 2026 projections.[ix] We project a 2025 uninsurance rate of 16.8% for the

[ix] Population data from the Texas Demographic Center displayed a growth rate of 4.7% from 2020 to 2023. We use these growth estimates and assume that the population grew at the same rate from 2023 to 2026. Thus, uninsurance

state as a whole and also include this baseline estimate for individual counties (Table 5). Some counties are too small to report data individually in the ACS public files, and for these we divide all non-individually-identified counties based on weights of county-level share sourced from population data from the Texas Demographer's Office in 2023.

Finally, we use the estimated change in county-level uninsurance rate to create a back-of-the-envelope calculation on the potential impacts regarding the number of uninsured hospital inpatient stays. To do so, we use our estimates from the change in county-level uninsurance rates and prior estimates of the relationship of the uninsured inpatient rate prior to the ACA on the share of uninsured hospital inpatient stays in Texas after the Affordable Care Act.[32]

IV. Results

Table 5 summarizes the main results of our estimates of the impact of enhanced subsidy expiration on Marketplace enrollment and uninsurance in Texas, overall and by county.

Our estimates in Table 5 suggest that between 665,929 and 1,450,449 Marketplace enrollees will not continue individual Marketplace coverage in Texas in 2026, representing declines of 17-37% from 2025. Here, our low-end (L) estimate is based on the more inelastic demand estimate (-.146) and the high-end (H) estimate is based on the less inelastic demand estimate (-.318).

Our demand elasticity estimates are generally smaller than other estimates in the literature. For example, existing estimates from other contexts (early ACA and the California Marketplace) suggest that a 10% increase in premiums reduces enrollment by 2-7%.[6,7] This implies the projected 115% increases in premiums could result in enrollment declines of 23% to more than 80% among affected populations. Our estimates, while not small, are on the more conservative end of this range.[x]

Table 5 also describes overall and county-specific expected loss in insurance coverage based on our assumption of some (45%) expected substitution of other coverage after

rate estimates are adjusted for growth rates when estimating the 2026 state population and the number of uninsured individuals.

[x] We do not include any additional adjustment on potential increases in expected premium from 2025 to 2026 into the model, as many people will face maximum contribution limits under 2025 premiums without the enhanced subsidies. Thus, the feature of the ACA protecting people from premium increases is binding and additional increases in premium in 2026, whether because firms are anticipating adverse selection or something else, will be borne by taxpayers. See Table 2 for an illustration of how the expiration is operationalized including an anticipated premium increase.

Marketplace disenrollment. Here we find that the loss in Marketplace coverage translates to 366,261 newly uninsured people on the low end and 797,747 newly uninsured people on the high end. We also translate these changes to uninsured rates. For example, our low-end estimates suggest that uninsurance would increase to 18.3%, while high-end estimates imply an increase to 20%. Given our baseline estimate of 2025 uninsurance is 16.8% among nonelderly Texans, this implies the expiration of enhanced subsidies would increase uninsurance between 1.5 to 3.2 percentage points.

Total insurance loss is largest in highly populated counties, such as Harris County, and smaller in absolute terms in non-metropolitan counties such as Baylor County. However, the uninsurance rates are projected to grow at a lower rate in many non-metropolitan counties than in metropolitan counties – with uninsurance rates increasing from 20.96% to 22.73%-24.82% in Harris County and only increasing from 16.88% to 18.44%-20.28% in Baylor County, for example.

We also estimated changes in enrollment and insurance coverage assuming a 50% increase and 150% increase in premium (rather than the 115% increase) and using our two elasticity estimates. A 50% premium increase is projected to cause Marketplace enrollment to fall by between 289,534 and 630,630 individuals, which would result in a statewide uninsurance rate of 17% to 18%. The impact is more severe in a scenario with a 150% premium increase, which is projected to cause an enrollment drop of between 868,603 and 1,891,890 people. This drastic loss of coverage would, in turn, push the state's projected uninsurance rate for 2026 to between 19% and 21%. The corresponding change in the number of uninsured individuals ranges from 159,244 in the most conservative scenario to 1,040,539 in the most extreme one. We do not provide these estimates by county, but these statewide estimates give a sense of the magnitudes.

Considerations for Rural Communities

Beyond the immediate impact of increased uninsurance, communities are likely to experience additional changes. Effects of premium increases in 2026 may be felt most strongly among rural residents who have lower average household income than urban residents, and have historically picked lower out-of-pocket premium plans than urban counterparts.[33] As a result, healthier individuals may disproportionately disenroll in rural areas, thereby increasing medical loss ratios for insurance companies for existing enrollees. One can expect that this will also be passed through to premiums, potentially

leading to future premium increases in the coming years. Anticipated adverse selection may also lead insurers to reduce plan offerings, thereby reducing choice for consumers – particularly gold plan offerings. Since Marketplace rating areas in Texas combined rural and urban counties beginning in 2023, any effects on prices and plan offerings will be felt for both rural and urban residents.

Another dimension in which a changing insurance landscape can affect health care access is through reductions in provider access. This can materialize through insurers focusing their plan benefits on "narrow networks", which have fewer providers available at the in-network price and thereby reduce access to care.[34] Existing evidence has shown that these plans were especially able to reduce premiums and tend to exclude expensive "star" hospitals.[35,36] But they come at a cost, with consumers likely to travel farther distances to receive specialty care and regular preventative care.

Health System Consequences

Increases in uninsurance can also have broader effects on the market for health care. Hospitals serve as effective insurers of last resort for uninsured individuals, and higher rates of uninsurance can negatively impact hospital operations and finances by increasing uncompensated care, thereby reducing revenue and limiting the ability of hospitals to invest infrastructure and staff.[37,38] Estimates from the Texas Hospital Association suggest that the level of uncompensated care amounts to $8.3 billion per year ($5 billion of which is reimbursed through supplemental payments).[39] Increasing uninsurance will increase this number and can have especially negative consequences for both rural hospitals and public or non-profit hospitals in large cities, who bear a disproportionate burden of uncompensated care.[40] For example, estimates suggest a decline in health spending for the nonelderly of $5 billion after expiration of enhanced premium tax credits, around 40% of which would be hospital spending.[41] Shifts in payor mix towards lower reimbursed and uninsured individuals can exacerbate existing financial pressures of hospitals and may lead to hospital closures or reduced service availability.

The final columns of Table 5 use our estimates of the changes in uninsurance rates from 2025 to 2026 and prior evidence on how this may affect hospital uninsured inpatient stays to estimate an upper bound on the increase in uninsured hospital inpatient share

of 0.32 percentage points or 2.5% relative to an estimated statewide baseline rate of uninsured inpatients 13%. In other words, we predict that the fraction of uninsured inpatients could increase by 2.5% at the average hospital as a result of enhanced subsidy expiration. These effects do not account for expected changes in emergency department utilization and revenues, which may also meaningfully change uninsured emergency department use because 30% of emergency care is paid for by commercial payors.[42]

Economic Effects

The economic impacts of health insurance on individuals are well understood[43–46]; we do not offer a comprehensive review. Evidence has shown that the lack of insurance is associated with problems paying off debt, and that insurance is protective against incurring medical debt.[47,48] Lack of insurance also discourages medical care receipt, with individuals more likely to forego and delay care.[49,50] This can lower overall consumer spending and can have important implications for lifetime earnings, as individuals struggling with untreated health conditions are less likely to participate in the labor force and are more restricted in their earnings potential.[51] Health insurance plays an important role in lifetime physical and financial health.

Comparative Analysis

Estimates of loss of individual Marketplace coverage following the expiration of enhanced subsidies vary. The Congressional Budget Office (CBO) official projections from June 2024 predicted Marketplace enrollment decreasing from 22.8 in 2025 to 18.9 million in 2026 with the expiration of subsidies, a nationwide loss of nearly 3.9 million enrollees next year, with a projected increase in uninsured of around 3 million, or roughly 75% of the Marketplace losses.[52] If proportionate to current enrollment, this would imply around 630,000 Texans would lose Marketplace coverage, with 470,000 uninsured. A KFF interpretation of updated CBO projections that incorporate other aspects of the recent budget reconciliation law anticipates 920,000 new uninsured Texans over the next ten years from enhanced subsidy expiration (for a total of 1.4 million new uninsured when including the other provisions).[53] The Urban Institute projects national Marketplace enrollment to decline in 2026 by 7.2 million and Texas-specific Marketplace enrollment to decrease by 1.8 million.[54] While some individuals will seek alternative insurance coverage, they estimate that uninsurance in Texas will increase by about 1 million people. Our estimates suggested between 665,000 to 1.45 million

lower Marketplace enrollment for Texans in 2026 and onward from the expiration of enhanced subsidies, resulting in 365,000 to 800,000 newly uninsured, which makes our estimates larger than the short-run CBO estimates but smaller than the ten year estimates and those published by Urban Institute.

Fewer individuals would be expected to forego coverage if Texas expanded Medicaid. In Texas, unlike in Medicaid expansion states, individuals with incomes between 100-138% FPL can only enroll in Marketplace coverage, while a similar individual in a Medicaid expansions state can only have been covered by Medicaid in 2025. Medicaid does not allow for premium cost sharing and will not experience changes in premium contribution in 2026. As a result, the same policy change – the expiration of enhanced subsidies - has a much smaller effect on health insurance coverage in Medicaid expansion states.

The exposure of low-income individuals in the Texas Marketplace is central to any enrollment projection. The divergence between our estimates and national projections may hinge on how one models the price sensitivity (elasticity) of this specific group. Because these individuals have very limited ability to absorb higher premium costs, they may be more likely to forego coverage than higher-income enrollees. The potential magnitude of this effect becomes clear when examining the concentration of these vulnerable enrollees in Texas's major urban counties.

For example, Harris County has 534,481 Marketplace enrollees with income below 150% of FPL in 2025 (69% of all enrollees). We expect that many of these individuals will lose coverage. Assuming for illustration that at least half of these individuals would lose coverage, implying that they are more price responsive than the average enrollee, this would increase the uninsurance rate by 6.6 percentage points in Harris County to 27.6% alone, ignoring any effect on higher- income Marketplace enrollees. Similarly, the number of Marketplace enrollees below 150% FPL is lower in Galveston County with 23,697 enrollees, or 60% of all enrollees. Here, the same elasticity for low-income Marketplace enrollees would increase the uninsurance rate by 4.0 percentage points to 18.9%. This demonstrates how the state's geographic concentration of low-income Marketplace enrollees can impact projections.

Limitations

The analyses included a number of assumptions to arrive at our findings. First, the CMS data is only available at the county level, as such, this means that our empirical specification can only estimate demand elasticities based on county-level Marketplace characteristics. Ideally, one would like to observe plan options and prices for each enrollee. Nevertheless, our elasticity estimates are reasonably close to other studies evaluating consumer responses in the ACA Marketplace – and generally lean conservative (predicting less coverage loss/less price responsiveness).

Second, our models are estimated using data from counties that report data. Unfortunately, counties with less than 11 enrollees do not report data. This means that very small counties are not represented in the data, as our control variables will be suppressed, and estimates need to be thought of as a broader representation of larger counties. However, no counties have total enrollment of less than 11 in 2025, and our panel level regression analyses with control variables include 80% of all county-year observations in Texas (99% without control variables). Thus, we expect little impact on our elasticity estimates. The issue of small counties also impacts our county population and uninsurance projections, which are projected based on historical population shares and do not represent actual survey responses in those locations. To arrive at insurance loss, we use estimates from the literature based on historical evidence on how Marketplace loss impacts overall healthcare insurance rates, as such, these estimates also include a degree of uncertainty, which we do not represent directly. Finally, our estimates assume that the current ACA policy landscape does not further change prior to open enrollment in the fall of 2025.

V. Conclusion

Our analysis clearly shows that without further action by policymakers, individuals should prepare for increased Marketplace premiums, and health systems and health care providers should prepare for increased numbers of uninsured Texans coming through their doors.

What could be done to prevent large increases in uninsurance? At the federal level, considering whether it is worthwhile to permanently extend the subsidies is one possibility. Our elasticity estimates suggest affordability is an important driver of enrollment in health insurance coverage, suggesting that the perceived value of health insurance to individuals differs significantly from its costs. Alternative federal policy mechanisms that can make policies more affordable have been proposed and can also

be considered, from management of risk pools to consideration of what belongs in essential benefits to premium support to funding more direct outreach.[55] States have significant roles in insurance markets, and the federal government could also allow and encourage them to use increased flexibility through waiver programs to innovate. At the state level, possibilities that might drive down premiums include reinsurance programs, state-based subsidies, or other mechanisms to improve the risk pool (such as Medicaid expansion). There is no shortage of ideas, and a majority of Texans believe the state is not doing enough to support health care for low-income residents.[9]

Of course, the opportunity cost of increased spending on health insurance subsidies is the programs that cannot exist if we spend scarce taxpayer resources here rather than there (or the consequences of increased federal deficits, which are increasingly a concern of economists across the political distribution). Questions such as whether this particular part of the income distribution should be a priority population for extra financial help compared to lower-income consumers must be considered; the relative benefits are outside the scope of our analyses. In the long-run, the largest determinant of health insurance premium growth is health care prices (costs) – without polices to address out-of-control price growth in the inpatient, outpatient, and pharmaceutical markets, both subsidy amounts and out-of-pocket costs will continue to increase for consumers and taxpayers while coverage will continue to erode.

Recent federal legislative actions will result in additional changes to the Marketplace. The One Big Beautiful Bill Act (OBBBA), a comprehensive bill signed into law in July 2025, both shortens Open Enrollment Periods and restricts the types of Special Enrollment Periods allowed.[56,57] It also imposes more rigorous documentation requirements for premium tax credit applications and a penalty for lack of proactive eligibility review ($5 monthly charge for unverified auto-enrollees), among other measures. While this study did not include an analysis of these Marketplace modifications, which will take effect through the open enrollment process for 2026 coverage, they are anticipated to intensify projected increases in uninsurance following the expiration of enhanced premium tax credits by the end of 2025.[58] The Congressional Budget Office estimates an additional 3.1 million nationwide, 560,000 from Texas, to become newly uninsured by 2034, attributed to these provisions of OBBBA impacting Marketplace.[59]

The prospects for ongoing progress in reducing uninsurance in Texas are currently dismal. Meaningful progress will require sensible market reforms to constrain price growth and ensure that all Texans can access essential health care.

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State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
Texas	3,966,226	-665,929	-1,450,449	-366,261	-797,747	18.5%	16.8%	18.3%	20.0%	0.15%	0.32%
County											
Anderson	5,666	-951	-2,072	-523	-1,140	19.3%	20.7%	21.9%	23.3%	0.12%	0.26%
Andrews	2,512	-422	-919	-232	-505	19.3%	15.9%	17.6%	19.6%	0.17%	0.36%
Angelina	14,197	-2,384	-5,192	-1,311	-2,856	19.3%	16.1%	18.1%	20.4%	0.20%	0.43%
Aransas	3,834	-644	-1,402	-354	-771	19.3%	16.3%	18.1%	20.4%	0.19%	0.41%
Archer	2,227	-374	-814	-206	-448	19.3%	11.7%	14.8%	18.4%	0.30%	0.66%
Armstrong	391	-66	-143	-36	-79	19.3%	15.9%	18.6%	21.7%	0.26%	0.57%
Atascosa	6,859	-1,152	-2,508	-633	-1,380	19.3%	16.6%	18.2%	20.2%	0.16%	0.35%
Austin	4,478	-752	-1,638	-414	-901	19.3%	17.1%	18.9%	21.0%	0.17%	0.38%
Bailey	933	-157	-341	-86	-188	19.3%	17.8%	19.5%	21.5%	0.17%	0.37%
Bandera	2,723	-457	-996	-251	-548	19.3%	17.4%	18.9%	20.7%	0.15%	0.32%
Bastrop	8,951	-1,503	-3,273	-827	-1,800	19.3%	19.5%	20.5%	21.7%	0.10%	0.22%
Baylor	420	-71	-154	-39	-84	19.3%	17.0%	18.5%	20.3%	0.15%	0.32%
Bee	2,519	-423	-921	-233	-507	19.3%	18.6%	19.6%	20.8%	0.10%	0.22%
Bell	35,438	-5,950	-12,960	-3,273	-7,128	13.2%	11.3%	12.3%	13.5%	0.10%	0.22%
Bexar	249,741	-41,932	-91,330	-23,062	-50,232	16.3%	14.3%	15.7%	17.2%	0.13%	0.29%
Blanco	1,760	-296	-644	-163	-354	19.3%	17.3%	18.9%	20.9%	0.17%	0.36%
Borden	491	-82	-180	-45	-99	19.3%	16.5%	27.2%	39.8%	1.06%	2.31%
Bosque	1,817	-305	-664	-168	-365	19.3%	18.9%	20.0%	21.4%	0.12%	0.26%
Bowie	11,608	-1,949	-4,245	-1,072	-2,335	19.3%	16.7%	18.2%	20.1%	0.16%	0.34%
Brazoria	42,790	-7,184	-15,648	-3,951	-8,607	14.6%	12.6%	13.8%	15.3%	0.12%	0.27%
Brazos	18,914	-3,176	-6,917	-1,747	-3,804	12.8%	11.5%	12.4%	13.4%	0.09%	0.19%
Brewster	974	-164	-356	-90	-196	19.3%	19.1%	20.4%	21.9%	0.13%	0.27%
Briscoe	221	-37	-81	-20	-44	19.3%	16.8%	18.7%	20.9%	0.19%	0.41%
Brooks	1,327	-223	-485	-123	-267	19.3%	14.1%	16.5%	19.3%	0.24%	0.52%

State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
Brown	7,225	-1,213	-2,642	-667	-1,453	19.3%	11.2%	13.5%	16.3%	0.23%	0.50%
Burleson	2,359	-396	-863	-218	-474	19.3%	16.2%	17.7%	19.5%	0.15%	0.32%
Burnet	5,508	-925	-2,014	-509	-1,108	19.3%	18.1%	19.3%	20.8%	0.12%	0.27%
Caldwell	5,378	-903	-1,967	-497	-1,082	19.3%	18.5%	19.8%	21.4%	0.13%	0.29%
Calhoun	2,416	-406	-884	-223	-486	19.3%	17.4%	18.9%	20.7%	0.15%	0.33%
Callahan	1,879	-315	-687	-174	-378	19.3%	17.2%	18.9%	20.8%	0.16%	0.35%
Cameron	70,385	-11,818	-25,740	-6,500	-14,157	27.0%	25.6%	27.5%	29.7%	0.19%	0.40%
Camp	2,140	-359	-783	-198	-430	19.3%	15.8%	17.9%	20.3%	0.20%	0.44%
Carson	695	-117	-254	-64	-140	19.3%	17.0%	18.5%	20.2%	0.15%	0.32%
Cass	3,510	-589	-1,284	-324	-706	19.3%	17.2%	18.7%	20.5%	0.15%	0.33%
Castro	1,053	-177	-385	-97	-212	19.3%	16.9%	18.7%	20.8%	0.18%	0.39%
Chambers	5,840	-981	-2,136	-539	-1,175	19.3%	17.8%	19.1%	20.7%	0.13%	0.29%
Cherokee	6,350	-1,066	-2,322	-586	-1,277	19.3%	17.4%	18.9%	20.7%	0.15%	0.32%
Childress	673	-113	-246	-62	-135	19.3%	17.8%	19.0%	20.5%	0.12%	0.27%
Clay	3,849	-646	-1,408	-355	-774	19.3%	9.3%	13.8%	19.0%	0.44%	0.97%
Cochran	465	-78	-170	-43	-94	19.3%	17.8%	20.1%	22.7%	0.22%	0.48%
Coke	262	-44	-96	-24	-53	19.3%	19.0%	20.0%	21.1%	0.10%	0.21%
Coleman	1,211	-203	-443	-112	-244	19.3%	15.4%	17.3%	19.6%	0.19%	0.41%
Collin	137,117	-23,022	-50,144	-12,662	-27,579	10.3%	8.6%	9.9%	11.4%	0.13%	0.27%
Collingsworth	357	-60	-131	-33	-72	19.3%	16.1%	17.8%	19.9%	0.17%	0.37%
Colorado	3,315	-557	-1,212	-306	-667	19.3%	17.1%	19.1%	21.4%	0.19%	0.42%
Comal	16,320	-2,740	-5,968	-1,507	-3,283	12.4%	11.2%	12.2%	13.4%	0.10%	0.22%
Comanche	1,876	-315	-686	-173	-377	19.3%	17.0%	18.7%	20.6%	0.16%	0.36%
Concho	325	-55	-119	-30	-65	19.3%	17.6%	18.9%	20.3%	0.12%	0.27%
Cooke	5,364	-901	-1,962	-495	-1,079	19.3%	17.2%	18.7%	20.5%	0.15%	0.33%
Coryell	5,522	-927	-2,019	-510	-1,111	19.3%	18.7%	19.5%	20.4%	0.08%	0.17%
Cottle	117	-20	-43	-11	-24	19.3%	20.4%	21.6%	22.9%	0.11%	0.24%

State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
Crane	686	-115	-251	-63	-138	19.3%	17.8%	19.7%	21.9%	0.18%	0.40%
Crockett	989	-166	-362	-91	-199	19.3%	6.4%	10.7%	15.8%	0.43%	0.93%
Crosby	820	-138	-300	-76	-165	19.3%	16.7%	18.7%	21.1%	0.20%	0.44%
Culberson	348	-58	-127	-32	-70	19.3%	18.5%	20.5%	22.8%	0.20%	0.43%
Dallam	944	-158	-345	-87	-190	19.3%	17.5%	19.1%	21.0%	0.16%	0.34%
Dallas	360,057	-60,454	-131,673	-33,249	-72,420	23.7%	22.6%	24.2%	26.0%	0.15%	0.33%
Dawson	1,166	-196	-426	-108	-235	19.3%	18.2%	19.4%	20.8%	0.12%	0.26%
Deaf Smith	2,560	-430	-936	-236	-515	19.3%	15.2%	16.9%	18.9%	0.17%	0.37%
Delta	901	-151	-329	-83	-181	19.3%	14.5%	16.5%	18.9%	0.20%	0.43%
Denton	113,436	-19,046	-41,484	-10,475	-22,816	11.6%	9.1%	10.3%	11.8%	0.12%	0.27%
DeWitt	2,531	-425	-926	-234	-509	19.3%	17.6%	19.1%	21.0%	0.15%	0.34%
Dickens	219	-37	-80	-20	-44	19.3%	16.8%	18.4%	20.2%	0.16%	0.34%
Dimmit	1,413	-237	-517	-130	-284	19.3%	17.1%	19.2%	21.7%	0.21%	0.46%
Donley	363	-61	-133	-34	-73	19.3%	17.5%	18.9%	20.6%	0.14%	0.31%
Duval	1,521	-255	-556	-140	-306	19.3%	23.7%	25.7%	28.0%	0.19%	0.42%
Eastland	2,206	-370	-807	-204	-444	19.3%	17.5%	19.0%	20.8%	0.15%	0.33%
Ector	31,550	-5,297	-11,538	-2,913	-6,346	25.1%	21.1%	23.2%	25.6%	0.21%	0.45%
Edwards	530	-89	-194	-49	-107	19.3%	19.3%	24.0%	29.6%	0.47%	1.02%
Ellis	19,964	-3,352	-7,301	-1,844	-4,015	15.8%	14.5%	15.5%	16.7%	0.10%	0.22%
El Paso	120,165	-20,176	-43,944	-11,097	-24,169	24.2%	23.6%	25.2%	27.0%	0.16%	0.34%
Erath	5,230	-878	-1,913	-483	-1,052	19.3%	18.9%	20.4%	22.1%	0.14%	0.32%
Falls	2,042	-343	-747	-189	-411	19.3%	17.9%	19.3%	21.0%	0.14%	0.31%
Fannin	4,017	-674	-1,469	-371	-808	19.3%	17.5%	18.8%	20.4%	0.13%	0.28%
Fayette	2,204	-370	-806	-204	-443	19.3%	18.5%	19.6%	20.9%	0.11%	0.23%
Fisher	585	-98	-214	-54	-118	19.3%	15.2%	17.2%	19.6%	0.20%	0.43%
Floyd	905	-152	-331	-84	-182	19.3%	16.8%	19.0%	21.6%	0.22%	0.47%
Foard	214	-36	-78	-20	-43	19.3%	17.6%	20.0%	22.9%	0.24%	0.53%

State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
Fort Bend	140,556	-23,599	-51,401	-12,980	-28,271	13.0%	10.7%	12.4%	14.4%	0.17%	0.37%
Franklin	1,679	-282	-614	-155	-338	19.3%	17.0%	19.0%	21.3%	0.19%	0.42%
Freestone	2,150	-361	-786	-199	-432	19.3%	18.1%	19.4%	21.0%	0.13%	0.28%
Frio	2,077	-349	-760	-192	-418	19.3%	17.6%	19.0%	20.6%	0.14%	0.30%
Gaines	2,367	-397	-866	-219	-476	19.3%	17.2%	18.5%	20.0%	0.13%	0.28%
Galveston	38,261	-6,424	-13,992	-3,533	-7,696	16.3%	14.9%	16.1%	17.6%	0.12%	0.27%
Garza	610	-102	-223	-56	-123	19.3%	17.0%	18.7%	20.6%	0.16%	0.36%
Gillespie	3,483	-585	-1,274	-322	-701	19.3%	21.8%	23.3%	25.2%	0.15%	0.34%
Glasscock	161	-27	-59	-15	-32	19.3%	15.9%	17.7%	19.7%	0.17%	0.38%
Goliad	801	-134	-293	-74	-161	19.3%	18.2%	19.6%	21.2%	0.14%	0.30%
Gonzales	2,371	-398	-867	-219	-477	19.3%	17.1%	18.5%	20.3%	0.15%	0.32%
Gray	2,339	-393	-855	-216	-470	19.3%	18.1%	19.5%	21.1%	0.14%	0.30%
Grayson	15,544	-2,610	-5,684	-1,435	-3,126	19.3%	17.4%	18.8%	20.3%	0.13%	0.28%
Gregg	20,746	-3,483	-7,587	-1,916	-4,173	19.9%	16.7%	18.7%	21.0%	0.19%	0.42%
Grimes	4,336	-728	-1,586	-400	-872	19.3%	16.0%	17.6%	19.6%	0.16%	0.36%
Guadalupe	14,244	-2,392	-5,209	-1,315	-2,865	10.8%	9.5%	10.3%	11.4%	0.09%	0.19%
Hale	3,575	-600	-1,307	-330	-719	19.3%	17.2%	18.6%	20.2%	0.14%	0.30%
Hall	403	-68	-147	-37	-81	19.3%	17.0%	18.8%	20.9%	0.18%	0.38%
Hamilton	916	-154	-335	-85	-184	19.3%	17.6%	18.9%	20.5%	0.13%	0.29%
Hansford	607	-102	-222	-56	-122	19.3%	18.4%	19.9%	21.7%	0.15%	0.32%
Hardeman	428	-72	-157	-40	-86	19.3%	16.6%	18.1%	19.9%	0.15%	0.33%
Hardin	5,344	-897	-1,954	-493	-1,075	19.3%	17.6%	18.8%	20.1%	0.11%	0.25%
Harris	771,858	-129,595	-282,268	-71,277	-155,248	22.5%	21.0%	22.7%	24.8%	0.18%	0.38%
Harrison	9,418	-1,581	-3,444	-870	-1,894	19.3%	17.3%	18.9%	20.9%	0.16%	0.36%
Hartley	392	-66	-143	-36	-79	19.3%	19.0%	19.9%	21.1%	0.09%	0.20%
Haskell	720	-121	-263	-66	-145	19.3%	16.7%	18.3%	20.3%	0.16%	0.35%
Hays	22,164	-3,721	-8,105	-2,047	-4,458	11.1%	10.2%	11.1%	12.2%	0.09%	0.20%

State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
Hemphill	380	-64	-139	-35	-76	19.3%	17.9%	19.4%	21.1%	0.15%	0.32%
Henderson	12,372	-2,077	-4,524	-1,142	-2,488	19.3%	16.0%	17.8%	19.9%	0.18%	0.38%
Hidalgo	200,636	-33,687	-73,373	-18,528	-40,355	28.4%	26.4%	28.9%	31.8%	0.24%	0.53%
Hill	3,980	-668	-1,455	-368	-801	19.3%	18.1%	19.3%	20.9%	0.13%	0.28%
Hockley	2,801	-470	-1,024	-259	-563	19.3%	16.3%	17.9%	19.9%	0.16%	0.35%
Hood	8,475	-1,423	-3,099	-783	-1,705	19.3%	17.7%	19.3%	21.1%	0.15%	0.34%
Hopkins	4,663	-783	-1,705	-431	-938	19.3%	17.1%	18.6%	20.4%	0.15%	0.33%
Houston	3,133	-526	-1,146	-289	-630	19.3%	18.0%	19.8%	21.9%	0.17%	0.38%
Howard	3,140	-527	-1,148	-290	-632	19.3%	17.6%	18.9%	20.4%	0.13%	0.27%
Hudspeth	1,564	-263	-572	-144	-315	19.3%	N/A	N/A	N/A	N/A	N/A
Hunt	11,823	-1,985	-4,324	-1,092	-2,378	19.3%	17.3%	18.6%	20.1%	0.13%	0.28%
Hutchinson	2,045	-343	-748	-189	-411	19.3%	17.8%	19.1%	20.6%	0.13%	0.27%
Irion	701	-118	-256	-65	-141	19.3%	6.3%	11.8%	18.4%	0.55%	1.20%
Jack	1,175	-197	-430	-109	-236	19.3%	18.5%	20.1%	21.9%	0.16%	0.34%
Jackson	1,619	-272	-592	-150	-326	19.3%	18.0%	19.4%	20.9%	0.13%	0.29%
Jasper	4,230	-710	-1,547	-391	-851	19.3%	16.8%	18.4%	20.3%	0.16%	0.35%
Jeff Davis	234	-39	-86	-22	-47	19.3%	19.7%	21.3%	23.1%	0.16%	0.34%
Jefferson	31,738	-5,329	-11,607	-2,931	-6,384	24.0%	22.2%	23.7%	25.6%	0.15%	0.33%
Jim Hogg	836	-140	-306	-77	-168	19.3%	22.7%	24.9%	27.6%	0.22%	0.48%
Jim Wells	5,778	-970	-2,113	-534	-1,162	19.3%	16.0%	17.8%	20.0%	0.18%	0.40%
Johnson	22,057	-3,703	-8,066	-2,037	-4,436	17.4%	15.6%	16.9%	18.3%	0.12%	0.27%
Jones	1,549	-260	-566	-143	-312	19.3%	18.6%	19.5%	20.6%	0.09%	0.20%
Karnes	1,430	-240	-523	-132	-288	19.3%	17.4%	18.6%	20.0%	0.12%	0.25%
Kaufman	19,883	-3,338	-7,271	-1,836	-3,999	17.2%	16.4%	17.6%	19.0%	0.12%	0.25%
Kendall	4,181	-702	-1,529	-386	-841	19.3%	18.7%	19.7%	20.9%	0.10%	0.22%
Kenedy	252	-42	-92	-23	-51	19.3%	N/A	N/A	N/A	N/A	N/A
Kent	63	-11	-23	-6	-13	19.3%	19.1%	20.2%	21.4%	0.11%	0.23%

State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
Kerr	6,240	-1,048	-2,282	-576	-1,255	19.3%	17.7%	19.2%	20.9%	0.14%	0.31%
Kimble	1,841	-309	-673	-170	-370	19.3%	0.4%	5.5%	N/A	N/A	N/A
King	17	-3	-6	-2	-3	19.3%	15.3%	16.3%	17.4%	0.10%	0.21%
Kinney	400	-67	-146	-37	-80	19.3%	17.9%	19.4%	21.2%	0.15%	0.33%
Kleberg	3,035	-510	-1,110	-280	-610	19.3%	18.0%	19.3%	20.8%	0.12%	0.27%
Knox	344	-58	-126	-32	-69	19.3%	19.4%	20.7%	22.2%	0.13%	0.28%
Lamar	7,427	-1,247	-2,716	-686	-1,494	19.3%	17.3%	19.1%	21.3%	0.18%	0.39%
Lamb	1,473	-247	-539	-136	-296	19.3%	17.0%	18.4%	20.1%	0.14%	0.31%
Lampasas	2,067	-347	-756	-191	-416	19.3%	18.4%	19.5%	20.8%	0.11%	0.24%
La Salle	777	-130	-284	-72	-156	19.3%	17.7%	19.2%	20.9%	0.14%	0.32%
Lavaca	1,985	-333	-726	-183	-399	19.3%	18.2%	19.4%	20.8%	0.12%	0.26%
Lee	1,560	-262	-570	-144	-314	19.3%	18.3%	19.3%	20.6%	0.11%	0.23%
Leon	1,977	-332	-723	-183	-398	19.3%	17.1%	18.6%	20.3%	0.15%	0.32%
Liberty	15,640	-2,626	-5,720	-1,444	-3,146	19.3%	15.7%	17.5%	19.6%	0.18%	0.38%
Limestone	2,109	-354	-771	-195	-424	19.3%	17.9%	19.0%	20.4%	0.12%	0.25%
Lipscomb	399	-67	-146	-37	-80	19.3%	19.0%	20.7%	22.7%	0.17%	0.37%
Live Oak	1,210	-203	-442	-112	-243	19.3%	18.3%	19.5%	21.0%	0.13%	0.27%
Llano	2,313	-388	-846	-214	-465	19.3%	17.8%	19.0%	20.5%	0.12%	0.27%
Loving	28	-5	-10	-3	-6	19.3%	N/A	N/A	N/A	N/A	N/A
Lubbock	39,264	-6,592	-14,359	-3,626	-7,897	14.6%	12.1%	13.5%	15.2%	0.14%	0.31%
Lynn	668	-112	-244	-62	-134	19.3%	17.9%	19.3%	21.0%	0.14%	0.31%
Madison	768	-129	-281	-71	-154	19.3%	13.6%	14.8%	16.3%	0.13%	0.27%
Marion	22524	-3,782	-8,237	-2,080	-4,530	15.2%	10.8%	11.8%	13.0%	0.10%	0.21%
Martin	92	-15	-34	-8	-19	19.3%	9.4%	11.3%	13.7%	0.20%	0.43%
Mason	1486	-249	-543	-137	-299	19.3%	13.1%	14.5%	16.1%	0.13%	0.29%
Matagorda	1462	-245	-535	-135	-294	19.3%	10.0%	11.8%	14.0%	0.19%	0.40%
Maverick	484	-81	-177	-45	-97	19.3%	14.2%	15.4%	N/A	N/A	N/A

State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
McCulloch	1112	-187	-407	-103	-224	19.3%	0.1%	3.6%	7.8%	0.35%	0.76%
McLennan	5240	-880	-1,916	-484	-1,054	19.3%	10.5%	N/A	N/A	N/A	N/A
McMullen	13060	-2,193	-4,776	-1,206	-2,627	19.3%	4.5%	N/A	N/A	N/A	N/A
Medina	6,082	-1,021	-2,224	-562	-1,223	19.3%	17.8%	19.2%	20.8%	0.14%	0.30%
Menard	263	-44	-96	-24	-53	19.3%	15.8%	17.5%	19.5%	0.17%	0.36%
Midland	27,944	-4,692	-10,219	-2,580	-5,621	10.5%	6.4%	8.1%	10.2%	0.17%	0.37%
Milam	2,531	-425	-926	-234	-509	19.3%	17.9%	19.1%	20.5%	0.12%	0.26%
Mills	443	-74	-162	-41	-89	19.3%	17.8%	19.0%	20.5%	0.12%	0.26%
Mitchell	758	-127	-277	-70	-152	19.3%	17.8%	18.8%	20.1%	0.10%	0.22%
Montague	2,241	-376	-820	-207	-451	19.3%	18.2%	19.5%	21.0%	0.13%	0.28%
Montgomery	76,194	-12,793	-27,864	-7,036	-15,325	18.7%	17.6%	18.8%	20.3%	0.12%	0.26%
Moore	2,305	-387	-843	-213	-464	19.3%	17.1%	18.4%	20.0%	0.13%	0.29%
Morris	1,751	-294	-640	-162	-352	19.3%	16.7%	18.5%	20.6%	0.18%	0.39%
Motley	110	-18	-40	-10	-22	19.3%	17.9%	19.3%	20.9%	0.13%	0.29%
Nacogdoches	6,923	-1,162	-2,532	-639	-1,392	19.3%	18.0%	19.3%	20.9%	0.13%	0.28%
Navarro	5,651	-949	-2,067	-522	-1,137	19.3%	18.2%	19.5%	20.9%	0.12%	0.27%
Newton	1,340	-225	-490	-124	-270	19.3%	17.7%	19.1%	20.7%	0.14%	0.30%
Nolan	1,376	-231	-503	-127	-277	19.3%	17.8%	19.0%	20.4%	0.12%	0.26%
Nueces	35,753	-6,003	-13,075	-3,302	-7,191	18.8%	17.4%	18.6%	20.0%	0.12%	0.26%
Ochiltree	1,232	-207	-451	-114	-248	19.3%	18.1%	19.6%	21.5%	0.16%	0.34%
Oldham	248	-42	-91	-23	-50	19.3%	15.7%	17.4%	19.4%	0.17%	0.37%
Orange	8,559	-1,437	-3,130	-790	-1,722	19.3%	17.3%	18.5%	20.0%	0.12%	0.27%
Palo Pinto	4,421	-742	-1,617	-408	-889	19.3%	16.5%	18.3%	20.5%	0.18%	0.40%
Panola	3,748	-629	-1,371	-346	-754	19.3%	15.4%	17.5%	19.9%	0.20%	0.44%
Parker	14,607	-2,453	-5,342	-1,349	-2,938	16.4%	15.7%	16.6%	17.8%	0.10%	0.21%
Parmer	841	-141	-308	-78	-169	19.3%	18.2%	19.3%	20.6%	0.11%	0.23%
Pecos	2,095	-352	-766	-193	-421	19.3%	17.6%	19.3%	21.4%	0.18%	0.38%

State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
Polk	10,149	-1,704	-3,711	-937	-2,041	19.3%	15.0%	17.3%	20.1%	0.23%	0.50%
Potter	15,678	-2,632	-5,733	-1,448	-3,153	22.7%	19.2%	20.8%	22.7%	0.16%	0.35%
Presidio	1,097	-184	-401	-101	-221	19.3%	20.4%	22.7%	25.5%	0.23%	0.51%
Rains	1,361	-229	-498	-126	-274	19.3%	17.9%	19.2%	20.7%	0.13%	0.28%
Randall	11,466	-1,925	-4,193	-1,059	-2,306	14.1%	12.7%	13.6%	14.7%	0.09%	0.20%
Reagan	307	-52	-112	-28	-62	19.3%	19.8%	21.0%	22.4%	0.12%	0.26%
Real	417	-70	-152	-39	-84	19.3%	18.1%	19.9%	22.1%	0.18%	0.39%
Red River	1,715	-288	-627	-158	-345	19.3%	16.5%	18.3%	20.5%	0.18%	0.39%
Reeves	1,976	-332	-723	-182	-397	19.3%	15.3%	17.3%	19.8%	0.21%	0.45%
Refugio	886	-149	-324	-82	-178	19.3%	16.5%	18.1%	20.0%	0.16%	0.35%
Roberts	106	-18	-39	-10	-21	19.3%	14.9%	16.5%	18.4%	0.16%	0.35%
Robertson	1,912	-321	-699	-177	-385	19.3%	17.0%	18.4%	20.0%	0.14%	0.30%
Rockwall	12,013	-2,017	-4,393	-1,109	-2,416	19.3%	17.8%	19.0%	20.3%	0.11%	0.24%
Runnels	1,193	-200	-436	-110	-240	19.3%	17.4%	18.9%	20.6%	0.15%	0.32%
Rusk	6,725	-1,129	-2,459	-621	-1,353	19.3%	16.7%	18.3%	20.1%	0.16%	0.34%
Sabine	1,949	-327	-713	-180	-392	19.3%	13.8%	16.2%	19.0%	0.24%	0.52%
San Augustine	1,380	-232	-505	-127	-278	19.3%	17.5%	19.7%	22.2%	0.22%	0.47%
San Jacinto	4,446	-746	-1,626	-411	-894	19.3%	16.3%	18.2%	20.4%	0.19%	0.41%
San Patricio	7,588	-1,274	-2,775	-701	-1,526	19.3%	17.4%	18.7%	20.3%	0.13%	0.29%
San Saba	683	-115	-250	-63	-137	19.3%	17.7%	19.2%	21.0%	0.15%	0.33%
Schleicher	254	-43	-93	-23	-51	19.3%	17.7%	19.1%	20.6%	0.13%	0.29%
Scurry	1,539	-258	-563	-142	-310	19.3%	17.9%	19.1%	20.5%	0.12%	0.25%
Shackelford	473	-79	-173	-44	-95	19.3%	19.3%	21.1%	23.3%	0.18%	0.40%
Shelby	3,571	-600	-1,306	-330	-718	19.3%	15.9%	17.7%	19.9%	0.18%	0.39%
Sherman	1,031	-173	-377	-95	-207	19.3%	N/A	N/A	N/A	N/A	N/A
Smith	29,395	-4,935	-10,750	-2,714	-5,912	19.0%	17.4%	18.8%	20.5%	0.14%	0.31%
Somervell	1,047	-176	-383	-97	-211	19.3%	17.9%	19.2%	20.7%	0.13%	0.28%

State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
Starr	18,603	-3,123	-6,803	-1,718	-3,742	19.3%	16.0%	19.5%	23.6%	0.35%	0.75%
Stephens	1,139	-191	-417	-105	-229	19.3%	17.1%	18.6%	20.4%	0.15%	0.33%
Sterling	301	-51	-110	-28	-61	19.3%	11.2%	13.9%	17.1%	0.27%	0.59%
Stonewall	116	-19	-42	-11	-23	19.3%	17.7%	18.9%	20.2%	0.12%	0.25%
Sutton	392	-66	-143	-36	-79	19.3%	18.1%	19.6%	21.3%	0.15%	0.33%
Swisher	927	-156	-339	-86	-186	19.3%	18.3%	20.0%	22.0%	0.17%	0.36%
Tarrant	245,049	-41,144	-89,614	-22,629	-49,288	17.5%	16.0%	17.3%	18.8%	0.12%	0.27%
Taylor	14,717	-2,471	-5,382	-1,359	-2,960	14.4%	12.3%	13.5%	14.9%	0.12%	0.26%
Terrell	79	-13	-29	-7	-16	19.3%	18.9%	20.3%	22.0%	0.14%	0.30%
Terry	1,803	-303	-659	-166	-363	19.3%	15.4%	17.4%	19.7%	0.19%	0.42%
Throckmorton	197	-33	-72	-18	-40	19.3%	16.5%	18.1%	20.0%	0.16%	0.34%
Titus	3,723	-625	-1,362	-344	-749	19.3%	17.4%	18.9%	20.6%	0.15%	0.32%
Tom Green	14,150	-2,376	-5,175	-1,307	-2,846	19.3%	16.6%	18.0%	19.7%	0.14%	0.31%
Travis	144,947	-24,337	-53,007	-13,385	-29,154	11.7%	10.2%	11.5%	12.9%	0.12%	0.26%
Trinity	2,083	-350	-762	-192	-419	19.3%	17.3%	19.1%	21.2%	0.18%	0.39%
Tyler	2,303	-387	-842	-213	-463	19.3%	17.3%	18.7%	20.3%	0.14%	0.30%
Upshur	7,404	-1,243	-2,708	-684	-1,489	19.3%	14.8%	16.9%	19.4%	0.21%	0.46%
Upton	255	-43	-93	-24	-51	19.3%	19.0%	20.0%	21.2%	0.10%	0.22%
Uvalde	3,770	-633	-1,379	-348	-758	19.3%	18.0%	19.9%	22.1%	0.19%	0.40%
Val Verde	8,979	-1,508	-3,284	-829	-1,806	19.3%	16.9%	19.3%	22.0%	0.23%	0.50%
Van Zandt	6,731	-1,130	-2,462	-622	-1,354	19.3%	17.9%	19.2%	20.7%	0.13%	0.28%
Victoria	10,024	-1,683	-3,666	-926	-2,016	19.3%	17.5%	18.8%	20.4%	0.13%	0.29%
Walker	6,320	-1,061	-2,311	-584	-1,271	19.3%	19.6%	20.6%	21.7%	0.09%	0.21%
Waller	24,865	-4,175	-9,093	-2,296	-5,001	19.3%	9.8%	14.6%	20.3%	0.48%	1.04%
Ward	1,523	-256	-557	-141	-306	19.3%	16.6%	18.4%	20.4%	0.17%	0.37%
Washington	3,137	-527	-1,147	-290	-631	19.3%	18.7%	19.8%	21.0%	0.10%	0.23%
Webb	50,322	-8,449	-18,403	-4,647	-10,122	31.2%	29.3%	31.4%	33.8%	0.20%	0.44%

State and County	2025 ACA Enrollment	Change in Enrollment (L)	Change in Enrollment (H)	Proj. Newly Uninsured (L)	Proj. Newly Uninsured (H)	2023 Uninsurance Rate	2025 Proj. Uninsurance Rate	2026 Proj. Uninsurance Rate (L)	2026 Proj. Uninsurance Rate (H)	Increase Uninsured Inpatient Share (L)	Increase Uninsured Inpatient Share (H)
Wharton	6,000	-1,007	-2,194	-554	-1,207	19.3%	17.2%	19.0%	21.1%	0.18%	0.38%
Wheeler	453	-76	-166	-42	-91	19.3%	18.6%	19.8%	21.1%	0.12%	0.25%
Wichita	17,260	-2,898	-6,312	-1,594	-3,472	16.6%	13.7%	15.4%	17.3%	0.16%	0.36%
Wilbarger	1,356	-228	-496	-125	-273	19.3%	16.6%	17.9%	19.5%	0.13%	0.29%
Willacy	3,336	-560	-1,220	-308	-671	19.3%	16.9%	18.9%	21.4%	0.21%	0.45%
Williamson	63,930	-10,734	-23,379	-5,904	-12,859	11.0%	9.6%	10.6%	11.8%	0.10%	0.22%
Wilson	4,700	-789	-1,719	-434	-945	19.3%	19.2%	20.3%	21.5%	0.11%	0.23%
Winkler	1,647	-277	-602	-152	-331	19.3%	13.3%	16.1%	19.3%	0.27%	0.59%
Wise	7,215	-1,211	-2,639	-666	-1,451	19.3%	18.5%	19.6%	21.0%	0.11%	0.25%
Wood	5,460	-917	-1,997	-504	-1,098	19.3%	17.6%	19.0%	20.7%	0.14%	0.31%
Yoakum	815	-137	-298	-75	-164	19.3%	18.8%	20.2%	21.8%	0.13%	0.29%
Young	2,120	-356	-775	-196	-426	19.3%	18.3%	19.7%	21.5%	0.14%	0.31%
Zapata	3,532	-593	-1,292	-326	-710	19.3%	15.9%	19.0%	22.8%	0.32%	0.69%
Zavala	1,612	-271	-590	-149	-324	19.3%	16.2%	18.3%	20.9%	0.21%	0.46%

Table 5. State County Level 2025 Marketplace enrollment, projected enrollment changes, uninsured, and uninsurance rates in 2026. (L) indicates based on the smaller elasticity; (H) indicates based on the higher elasticity. Cells labeled N/A did not have sufficient sample size to support individual estimation.