THE UNIVERSITY OF HOUSTON
INSTITUTE FOR RESEARCH ON WOMEN, GENDER & SEXUALITY

Ongoing Evaluation of Harris County's Early REACH Contracted Slots Child Care Program, Second Annual Report (June 2026)

Prepared by:
Griselda Barcenas, Coleen Carlson, David J. Francis, Willa Friedman, Elizabeth Gregory, Zachary Hough, Elaine Liu, Itzel Martinez, Fan Wang, Yuwei Zhang

EXECUTIVE SUMMARY

This is the second of four reports in the ongoing evaluation by the UH IRWGS of the Harris County Department of Economic Equity and Opportunity's Early REACH Program (ER). ER was initiated as a pilot, and funded with federal American Rescue Plan Act (ARPA) dollars, sufficient to cover the cost of 800-to-1,000 contracted slots in high-quality child care deserts from June 2023 through September 2026. The program aims to begin to address the national shortage of affordable child care by providing free, high-quality care for children whose families face economic hardship and/or live in areas of Harris County with a high Social Vulnerability Index.

Of the roughly 332,000 children 4 and under in Harris County, at least 152,400 would be eligible for a contracted slot under ER's "85% of State Median Income" criterion. Even with multiple sources of federal child care funding, in Harris County there is a federally funded slot available for fewer than 1 in every 5 eligible children (17.9%).

Key Insights

1. Early REACH had positive effects on primary caregiver employment, including an overall 57% increase in transition to employment over non-Early REACH primary caregivers and an 11% increase in the job-retention rate.
2. The transition into employment for those in the program was 18.6 percentage points higher in the first year (relative to non-participants), and 27.7 percentage points higher for those in the program 12-24 months, indicating a positive effect of time-in-program.
3. Though there is an Early REACH center within 2.65 miles on average from PCs' homes, Early REACH families travel an average of 6.73 miles to their enrolled Early REACH provider. This likely reflects a combination of caregiver preferences, the fact that in some parts of Harris County centers were far spread, and the limited availability of ER slots.
4. While much of the ER-funded capacity substituted for pre-existing slots rather than opening new ones, enrollment grew 25% above the 2022–23 baseline among the ER center subsample, compared with 2.7% growth among non-ER centers over the same period.
5. Over its time in operation, the Early REACH program has reduced average center vacancy rates and cost paid per student, and increased the total number of slots filled/children enrolled.
6. Staffing levels and staff wages continued higher at ER centers than at non-ER centers and tuition levels at both rose at similar rates.

Principal Findings of This Report

Effects for Parents and Families

Effects on Primary Caregiver (PC) Employment

- Early REACH (ER) again showed a positive effect on employment for PCs: We find that ER **increased** the **probability of transitioning** from unemployment **into employment** by **24.0 percentage points** relative to comparable PCs who never enrolled in ER— a **57.5% increase in the unemployment-to-employment transition** for ER compared to non-ER PCs.
- Analyzing job retention, we document that for PCs already employed upon entering the ER program, **ER increased the probability of remaining employed by 8.1 percentage points**. This is **an 11% increase** for ER compared to non-ER PCs.
- **Overall, ER participation increased PC employment by an estimated 14.8 percentage points** relative to the change observed among comparable non-ER PCs, whose employment declined over the same period.

[1] Time-in-program analysis can involve no comparison group so there is no comparative increase to report.

- Additionally, we examined how increased length of **time-in-program affects employment**:
  - During the **first 12 months** after enrollment, ER increased the probability of transitioning into employment by **18.6 percentage points**. After families had been enrolled for 12 to 24 months, the estimated effect **rose to 27.7 percentage points**.[1] The effect **over two years was 49% higher than that over one year**,
  - Likewise, the **probability of remaining employed increased over time: a 3.5 percentage points** greater increase in the first year and an 8.5 percentage points greater increase in the second year and beyond.
  - Taken together, overall employment also increased with duration in ER: **During the first 12 months** after enrollment, **ER increased overall primary caregiver employment by 8.6 percentage points** (both those employed and unemployed at entry). After families had been enrolled for **12 to 24 months**, the estimated effect **rose to 16.7 percentage points**.
  - These findings indicate that **longer duration in ER positively affects PCs' work status**, in both transitioning into and retaining employment.

Distance Travelled for Child Care

- We provide an **overview of the distance from all ER family homes to all child care centers**, Texas Rising Star centers, and ER centers as well as the distances travelled to access care, using ER family address data and Texas child care operations (Health and Human Services) data.
- While on average there is an ER center within 2.65 miles of each ER home, **ER families travel an average of 6.73 miles to their enrolled ER provider**.
  - Primary caregivers may choose centers based on proximity to home or to workplace, as well as other center characteristics. Their choices are also limited by where ER slots are open at their time of enrollment—an effect magnified by ER's pilot status.

Effects for Child Care Centers

Total Available Slots

- We explored how many child care slots were added to the total slot offerings per center among a subset of 17 ER centers for whom the relevant data was available. We find that total slots increased over time (including both those funded by ER and those at the same centers that were not ER-funded). **Total enrollment at the subsample of ER centers grew about 25% above their 2022–23 baseline, versus about 2.7% at non-ER centers.**

Staffing, Wages, and Tuition

- The Round 2 results again show that ER centers had **higher staffing levels** than non-ER centers in 2025–26.
- Results also suggest continued **adherence to the ER wage policy and sustained wage differences** between ER and non-ER centers.
- In 2025–26, **tuition** for non-ER families in ER and non-ER centers continued to **increase over time, at similar levels**.

Effects over Time on Average ER Program Vacancy Rates, Cost per Slot, and Total Slots Filled per Month

- The pattern of higher vacancies when centers enter the program and low vacancies once a steady state of enrollments has been achieved, documented in Annual Report 1 (AR1), continued in the recent data (through April 2026), with an average 10.1% of slots per month vacant overall, and an **average 4.4% slot vacancy excluding the ramp-up period** (the first five months of the ER program) – an efficient pattern.
- Likewise, ER's average monthly tuition cost per child served was roughly $1,900 over the entire period, but **declined to $1,500 per child by April 2026**, as a steady state was achieved. As with any program that begins fully vacant and then fills, the longer the program is in operation, the lower the overall cost per child served.
- Using Baker Ripley's ER payment data, we document that the monthly average number of total slots filled was **762** (**820** excluding the ramp-up period).

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FACT SHEET **JUNE 2026**

This is the second of four reports in the ongoing evaluation of the Early REACH (ER) project, to be completed by December 2026.[2] We present findings based on the second round of Center and Family surveys, initial application data, payment data, enrollment data, ER center director interviews, and distance calculations. This report develops upon the findings offered in the first annual report (AR1) on employment effects, the program's efficiency in filling slots/cost per filled slot, and effects on center staffing, wages, and tuition. It augments those findings with analyses of the role of distance-from-home on families' center selection, expansion of center slots, and more. Subsequent reports will further expand on these analyses and on the range of issues addressed, to gauge economic and other structural impacts of the program on centers, families, children, graduated families, workforce, and the community.

Methodology

For our analysis, we sent surveys to the directors of each of the 28 currently active ER centers, and for comparison, we sent surveys to 1,181 child care centers throughout Harris County, with 92.9% and 11.9% response rates, respectively. The set of comparison centers we reached out to includes all child care centers in the same zip codes as the ER centers as well as all neighbor zip codes. We also reached out to all primary caregivers who applied to the ER program, including 703 ER recipients and 1,682 ER applicants who did not receive ER, with 80 percent and 30 percent response rates, respectively. Using respondent data, our caregiver comparison is based on the differential employment transition rates for ER caregivers and non-ER caregivers conditional on prior employment status and controlling for observed characteristics of caregivers. We provide descriptive patterns of enrollment, wage, and tuition changes for ER-centers over the course of ER implementation, and we contrast these with patterns from non-ER centers.

1. SETTING

1.1 Early REACH Program Framework

The Early REACH program (ER) was initiated as a pilot, and funded with federal ARPA dollars, sufficient to cover the cost of roughly 800 contracted slots in places of high need, including high-quality child care deserts, from June 2023 through September 2026 (which would total roughly 31,200 monthly slots over the life of the program).

The program was initiated by onboarding 26 pre-existing child care centers over the period June-December 2023 (the large majority were ranked level 3 or 4 in the Texas Rising Star [TRS] program, and a few were rated TRS 2 with plans to improve), offering roughly 820 slots consistently since February 2024 (see section 2).[3] Over the course of the pilot, seven centers have exited and been replaced by new centers or with expanded ER slots in centers that were already participating. Roughly 1,900 children have been part of the ER program to date.

Per the Policy Manual, through ER: "Harris County will partner with existing child care centers to offer high-quality spaces to prioritized families. Spaces will be available to children ages 0 to 4 who either

- live in areas of Harris County with a high Social Vulnerability Index, and/or
- whose families face economic hardship.

In addition to increasing the number of children served in high-quality centers, the pilot aims to stabilize small child care businesses by securing a livable wage for child care workers."

The ER program also assists centers by contracting with them to cover a specific number of slots, whether or not they are filled (in order to sustain payroll in the gap between the departure of one child in a slot and the arrival of the next).

1 Raising Educational Access for Children in Harris County

2 The project was initiated in Spring of 2023, but due to setbacks with a prior provider, the economic/structural evaluation component was not active until June of 2024. Due to the absence of the evaluator in the planning phase, no randomization process or data-collection framework had been established; so extra steps were needed over the first few months of our work to generate appropriate data-collection and spot-distribution systems. The project implementation team at Baker Ripley has collaborated with the UH team to resolve those issues (see sidebar for details).

3 TRS features three certification tiers—Two-Star, Three-Star, and Four-Star—rewarding providers who exceed standard state licensing in quality standards.

ER centers are distributed across Harris County (based on Precinct and assessed need). Where possible, the program aims to expand affordable slots in high-quality child care deserts: this may be done by more effectively subsidizing pre-existent slots in high-quality centers there through the ER model, by adding new slots in those centers, and/or by improving the quality of child care in those and other centers.

Additionally, ER provides centers with teacher training/coaching (through United Way) and center-owner business training/coaching (through Civitas). ER is also designed to provide families with benefits beyond those provided in other federally funded child care subsidy programs by expanding on the limited hours offered at Head Start; and improving on the funding model of the Texas Workforce Commission (TWC)/Gulf Coast Workforce Solutions (GCWS) child care scholarships. TWC requires a co-pay and that recipients have or get a job or enter a training program, quickly. Moreover, such traditional federal funding models cut off recipients' funding when their wages rise past the 85% State Minimum Income (SMI) threshold, creating a benefit cliff, whereby even a minute raise may lead to a dramatic net loss of resources. This funding pattern has been critiqued as a poverty trap, as mothers may refuse raises or promotions because they would jeopardize their child care and, hence, their jobs.[4] In the ER model, slots remain available through the graduation for all children admitted to the program, if their family met the financial criteria on entry.

Children are eligible for Early REACH if they:

- Are age 0 to 4
- Live in Harris County
- Meet at least one of the following criteria:
  - Live in a family that earns 85% or less than the State Median Income (SMI)
  - Live in an area of high need (.75 or above) per the Social Vulnerability Index
  - Are experiencing homelessness
  - Are in foster care
  - Receive WIC, SNAP, TANF, free or reduced lunch, or SSI income (supplemental nutrition and cash assistance programs for needy families)

One online source indicates that high-quality child care in Houston can cost more than $3,000/month, and in 2022 paid care averaged $1,100/month for full-time, full-day programs of all quality levels.[5] While most paid child care covers the full workday, most public preschool programs have limited hours, leaving working parents to locate after-school care and summer care, or, if they don't succeed, then to work only part time or exit the workforce.

1.2 Harris County Child Demographics, Child Care Demand and Fertility Trends

Child Demographics and Access to Federally Funded Care

Per our analysis of 2024 American Community Survey (ACS) data, Harris County is home to about 336,000 children four years old and under, and, of those, at least 152,000 children— almost half—would be eligible for ER by the "85% of SMI" criterion.[6] At the onset of the program, admission was on a first-come, first-served basis, provided that applicants met the eligibility requirements. This served the goal of filling the initial vacancies quickly to get the program underway, but it meant that there was no prioritization by relative need within the group of eligible applicants, and those who heard about the program first had a greater chance of admission.

Following our discussions with Baker Ripley in August 2024, the program was revised to prioritize enrollment through a points-based system that favors the most vulnerable children. This means that more of those enrolled since October 2024 are likely to be among the roughly 79,000 children age 4 and under who live under the federal poverty line (FPL) in the county, as indicated in Table 1.2.1, or who are otherwise highly vulnerable. Upcoming reports will explore the degree to which prioritization has or has not affected the social vulnerability levels of the pool of enrolled children.

4 Derek Thomas, "The Cliff Effect: One Step Forward, Two Steps Back—Policy Design as a Disincentive for Eocnomic Mobility," *publicINreview* vol. 1, no. 3 (2013): Issue 3.

5 Brightwheel, "2023 Cost Guide for Houston Daycares and Preschools," online.

6 About 3,700 children in the ACS lacked a valid income variable so while the total ACS estimate is 336,533, for the purposes of this analysis, and since there is no reason to think the demographics of the omitted group differ notably, we discuss only those with the valid variable. For reference, here is the full demographic breakdown:

Race/ethnicity combined	Number of children 4 and under	Percent	Cumulative
NH White-single race	57,572	17.11	17.11
NH Black-single race	60,536	17.99	35.10
NH Asian/PI-single race	15,134	4.49	39.59
Hispanic	183,635	54.57	94.16
NH-multiple race	16,691	4.96	99.12
NH-Other	2,965	0.88	100
Total	**336,533**	**100**	**100**

Table 1.2.1 Harris County Children 4 and under, by Race/Ethnicity, % at or below FPL, % at or below 85% of State Median Income (eligible for Early REACH) ACS 2024

	Number of children	% of Total	# FPL	% FPL	# 85% SMI*	% 85% SMI
Total	332,838	100.00	79,468	23.88	152,400	45.79
NH White	57,240	17.20	3,923	6.85	8,552	14.94
NH Black	58,829	17.67	22,279	37.87	36,370	61.82
NH Asian	14,686	4.41	1,838	12.52	3,171	21.59
Hispanic	182,427	54.81	49,602	27.19	99,198	54.38
NH Multiple Race	16,691	5.01	1,621	9.71	4,025	24.11
NH Other	2,965	0.89	205	6.91	1,084	36.56

For this table, we use only those with a valid income variable (see note 6).

If their parents are employed, in school, or actively looking for work, those same children are also eligible for two other federally funded child care programs: the Gulf Coast Workforce Board's Workforce Solutions child care scholarships, and the Head Start program, which offers slots only to those at or under the FPL.

The ER program augments the federal child care dollars long supplied to Harris County families through those two programs, and it aims to improve upon their operating models. Taken together, the three federally funded systems provide substantially fewer slots than needed, as indicated by the numbers of slots funded and the queues (see Table 1.2.2), and by the overall numbers of eligible children (above)—though not all families want their children in child care. Recently inflation has decreased the number of slots available through GCWS. In Houston, Bezos Academy also supplies 299 free child care slots to families below FPL, and some churches supply some slots.

Of the at least 152,400 HC children eligible, about 27,295 currently receive federal funding through one of the three programs, and almost 26,000 are in queue. The 27,295/152,400 ratio means that **there is a federally funded slot available for fewer than 1 in every 5 eligible children** (17.9%). If all the slots went to children in families at or under the FPL (based on prioritizing the neediest), the ratio would be 27,295/79,468—meaning that only about **one third of the most needy children** (34.4%) would have access.

While some of this unmet demand could be met by family care, that may be less regular or create other complexities for working families. Lack of access to professional child care may be a particular issue for immigrant families, who often do not have grandmothers or other family members nearby who might provide free child care.[7] Insofar as at least forty-two percent of Harris County children 4 and under have at least one immigrant parent (ACS 2024), these factors combine to indicate that there is significant unmet underlying demand for professional child care in Harris County.

Fertility Trends and Child Care Demand

Demand for child care links to the number of children present in a region, the number of parents who want child care, and the number who can afford it. Population aged 4 and under correlates directly to the number of births over the past five years, with some in- and out-migration of children added in.

Harris County fertility rates have fallen markedly since 2007, as they have nationally, so even as the population of women aged 15-44 increases, the number of births has declined (Tables 1.2.3 and 1.2.4). This affects workforce in both the near term (more young women remain in the workforce) and the long term (fewer children age up into the workforce when they reach 18, at least through 2043).

Table 1.2.2 Sources of Federal Child Care Funding in Harris County *

Entity Name	# of Harris County Slots	# of Harris County Kids in Queue	Avg $ Spent Annually/Child	Total $ Spent Annually in Harris County	Cost to Family
TX Workforce Commission/ Gulf Coast Workforce Solutions	21,775 *(65% of GCWS total)*	25,763 *(Harris County children in GWCS queue, July 6, 2026)*	$11,000~ *[dividing the total by the slots]*	$245,050,000~ *[65% of GCWS total]*	Small daily co-pay
Head Start & Early Head Start	4,700~	NA	$14,000~ *[averaging EHS & HS, proportionately]*	$65,800,000~	Free
Early REACH	820	0	$18,000 *[dividing the total by the slots]*	$15,000,000 *[3.3 yrs total]*	Free
Total	**27,295~**	**25,763**		**$326,095,000~**	

** These numbers combine informed estimates with current specifics. Numbers for GCWS were provided either directly or from their website (about 65% of the population of the Texas Gulf Coast region live in Harris County). Data for Head Start provided by the Harris County Department of Education directly, and by Avance and GCCSA via their websites. Data on the number of Texas Education Freedom Act vouchers to be distributed for child care starting in mid-August 2026 is not yet available and will only briefly coincide with ER operation.*

7 IRWGS, Rapid-Harris County Data Update: Immigrant and Refugee Parents (March 2026).

Table 1.2.3 Number of Births and Fertility Rates in Harris County, TX, in 2007, 2010, 2015, 2020, 2023, 2024

Year	# of Births	Population of Females 15-44	Fertility Rate
2007	71,409	873,079	81.79
2010	68,219	910,505	74.92
2015	73,478	996,641	73.73
2020	63,813	1,025,724	62.21
2023	65,027	1,052,099	61.81
2024	63,829	1,098,562	58.10

(CDC, Wonder Database: Births)

Table 1.2.4 Estimated Number of Children Ages 0 through 4 in Harris County, TX, by Single Year of Age, 2024

Age	Number
Total 0-4	332,838
Less than age 1	66,231*
Age 1	60,644
Age 2	65,364
Age 3	66,149
Age 4	74,450

(American Community Survey estimates)

**The numbers in these two Tables differ because the ACS data is an estimate based on the subset surveyed while the CDC data is based on actual birth certificates.*

Fertility declines are in large part due to young women delaying family (Table 1.2.5). Rates have risen among older women over time, and may continue to rise as young people age up, finish school, establish themselves in the workforce and feel ready to support a family.

Table 1.2.5 Fertility Rates by Age of Mother, Harris County, TX, 2007, 2014, 2021, 2023, 2024

Harris County	15-19	20-24	25-29	30-34	35-39	40-44
2007	63.26	132.84	123.42	102.54	50.42	10.85
2014	37.58	101.12	113.08	106.33	55.03	12.85
2021	19.96	76.32	98.47	97.98	56.22	13.69
2023	19.48	74.04	99.44	97.98	58.52	14.08
2024	17.98	66.6	92.3	92.75	56.51	14.41

Between 2023 and 2024, the Harris County overall fertility rate fell 6%: including declines among women 15-39 and a rise among those 40-44. Despite the declines, Texas rates remain substantially above the national average. For example, in 2024 the national teen rate was **12.58** births / 1000 women aged 15 to 19; the Texas teen rate was **18.47**; Harris County's rate was **17.98**; New Hampshire's, the lowest teen rate, was **4.58; while Mississippi's, the highest, was 22.77.**

While specific rates by age differ, a similar trend—with big declines among young people and small rises among older age groups, is visible nationally, continuing into 2025 (state and local data are not yet available). Fertility declines are spurred by multiple factors, including: more reliable birth control, decreased in-person interaction among young people due to Smartphones and video games, economic pressures, lingering Covid effects, etc.

Falling births might be read to signal a lessening need for child care, but insofar as potential parents often cite child care's unaffordability as a reason for their delay, **the decline in births may itself be read as a signal that more affordable child care slots are needed**. And because there have long been too few affordable slots for the many parents who would like to access them, even though the number of children born per year has declined by almost a third since 2007 (reflected in school closings across the state), the underlying demand for more slots remains, to meet the needs of those present.

1.3 Program Goals & Potential Workforce Effects

The Early REACH program addresses at least four issues:

- The need to prepare children to succeed in school, through high-quality early childhood educational programs, for families who so choose.
- The need to support parents who want to work or go to school but can't afford child care on their own.
- The need to pay a living wage to child care workers, for fairness and because that enhances quality by attracting more skilled workers and retaining them more consistently.
- The instability of child care businesses dependent on students being steadily present, which was highlighted during COVID but is always the case when the money (including subsidies) follows the child.

All of these items have workforce components, impacting:

- Working Parents in the present: Parents are enabled to work FT when they have FT care.
- Children, the workforce of the future: Investment in Early Childhood Education upskills future workers and increases their overall likelihood of success in life.
- Child care workforce: Child care businesses increase and cut employees based on the stability and size of their demand and are better able to hire skilled workers and retain them when they pay a better wage.

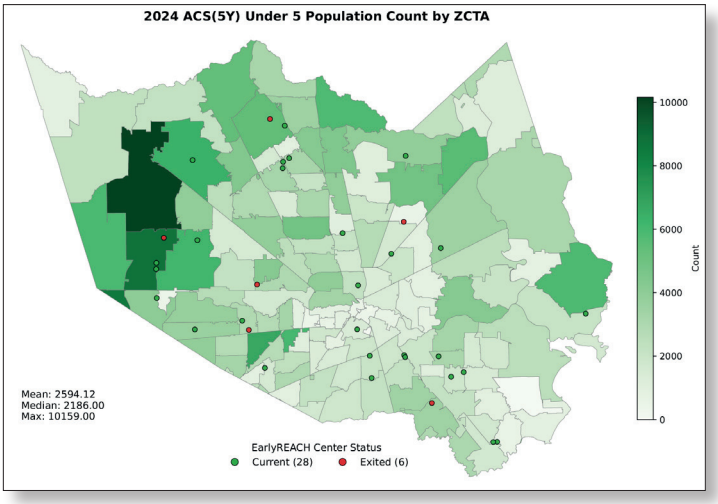
Ongoing national research suggests that, similar to public education, the benefit over time of investment in early childhood education outweighs the initial cost through economic ripple effects across the community in the near and long terms. Such effects are hard to track directly, but as Robert Lynch has argued, the costs of public assistance, remedial services, and criminal

justice decline when children are provided with a strong early education; and Humphries et al. have found that the direct effect of taxes paid over time by employed mothers offsets much of the cost of investment in Pre-K.[8] Whether child care is worthwhile is not at issue in this evaluation; instead, we examine the economic and structural outcomes of this program—for centers, families and the community.

1.4 Maps, Population, Poverty, and Early REACH Center Locations

As discussed earlier, the number of children aged 4 and under in Harris County is roughly 336,000 (ACS 2024). Figure 1.4.1 maps this population by Zip Code Tabulated Area,[9] along with the locations of the 34 centers that have participated in the ER program to date. The figure shows the variation in the distribution of children across the county, with some higher population zip codes on the west side of the county. The zip code with the highest under 5 population was 77433—the Cypress area.

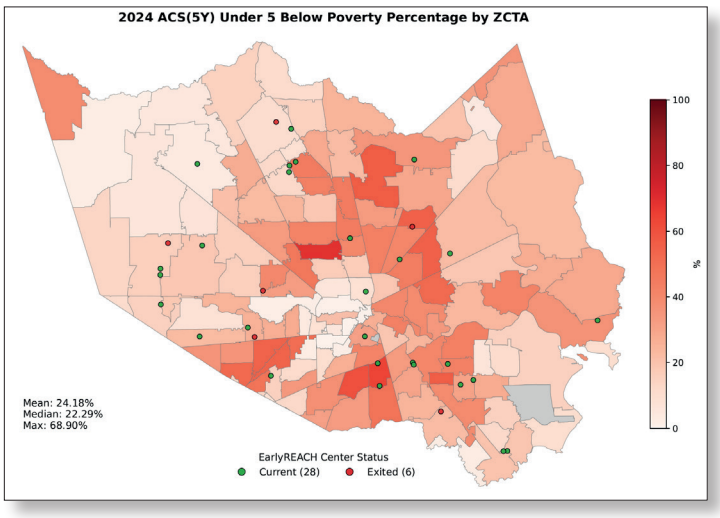
Figure 1.4.1



Given the motivation behind the ER program's design, we look also at the presence of child poverty across the county. Figure 1.4.2 maps the percentage of children under 5 living in a household with an income below the Federal Poverty Line (FPL).

In this figure, we can see that higher poverty rates cluster largely (though not solely) in the county's center. The highest under 5 poverty rate by zip code was 68.9%. ER centers were selected for County coverage, and were based in, or in proximity to, high-quality child care deserts and areas with a high Social Vulnerability Index.[10]

Figure 1.4.2



1.5 Distribution of distance between families, Early REACH, and non-ER centers

In this section, we examine the geography of child care in Harris County. Using child care operations data from the Texas Health and Human Services Commission (HHSC), we approximate the county's network of child care providers. By combining these data with ER application data, we examine how demand for child care relates to currently available resources.

The HHSC operations data include various data points on licensed child care providers in Texas. At the time of this report, the HHSC dataset included records for 1,681 licensed child care centers and homes in Harris County. Because ER contracted only with licensed child care centers, we excluded child care homes from the analysis, leaving 1,484 child care centers.

As part of the ER application, families submitted their home address. For this analysis, we excluded ineligible applicants, with the primary eligibility requirement being that the applicant's address was located in Harris County. Because this is a geographic analysis, we also excluded applications that were missing an address or had an address we were unable to verify. This left 2,750 applications for analysis.

The applications span 142 ZIP codes. The most common ZIP code was 77449, which is in the Katy area. However, by a large margin, the most common city was Houston, with roughly 1,900 applications, followed by Katy with approximately 190 applications. The table below shows the five most common cities among applicants.

8 Robert Lynch, *Exceptional Returns: Economic, Fiscal, and Social Benefits of Investment in Early Childhood Development* (Economic Policy Institute, 2004); and John E. Humphries et al., "Parents' Earnings and the Returns to Universal Pre-Kindergarten," *NBER Working Paper* 33038 (2024). See also, F. A. Campbell et al., "Early childhood education: Young adult outcomes from the Abecedarian Project," *Applied Developmental Science*, 6:1 (2002): 42-57; James Heckman and Ganesh Karapakula, "Intergenerational and Intragenerational Externalities of the Perry Preschool Project," *NBER Working Paper* No. 25889 (2019); Arthur J. Reynolds, et al., "Age-26 Cost-Benefit Analysis of the Child-Parent Center Early Education Program," *Child Development* 82:1 (Jan-Feb, 2011).

9 ZCTA, the Census Bureau's approach to zip codes, is used interchangeably with Zip Code unless otherwise stated.

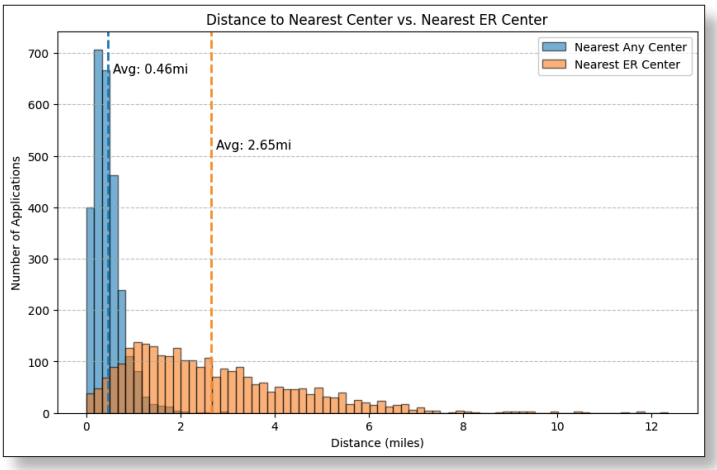
10 Per Texas Policy Lab's 2022 child care desert map, of the ER centers featured there, all were located in quality child care deserts.

Table 1.5.1

Top 5 Cities - *by number of applications*	
City	Application
Houston	1,907
Katy	187
Spring	132
Pasadena	117
Humble	117

When examining the geography of child care, one key question is how far families may need to travel to reach a provider. The graph below (Figure 1.5.1) shows the distribution of distances both to the nearest child care center and to the nearest ER center. Overall, child care centers appear to be relatively well dispersed across the county. On average, families would need to travel only 0.46 miles to reach the nearest child care center. The average distance to the nearest ER center is also relatively short, at 2.65 miles, but in some areas of Harris County, particularly in northern areas such as Huffman and Crosby, the nearest center simply is 10 miles away. In other cases some families travel far because the center nearest them may not have slots available when they apply.

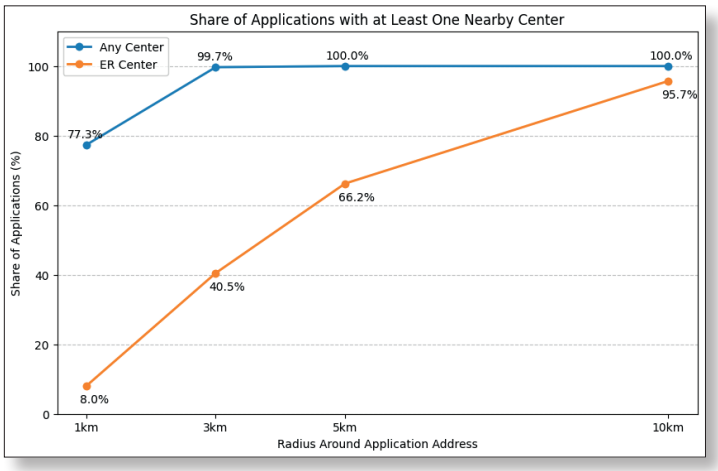
Figure 1.5.1



Another important question is the supply of child care available to families. This depends on the distance used to define nearby supply. To examine this, we identified all centers located within 1 km, 3 km, 5 km, and 10 km of each application address. First, we examine whether any nearby supply exists at all. Figure 1.5.2 shows, for each distance, the share of applications with at least one center within that distance and the share with at least one ER center within that distance.

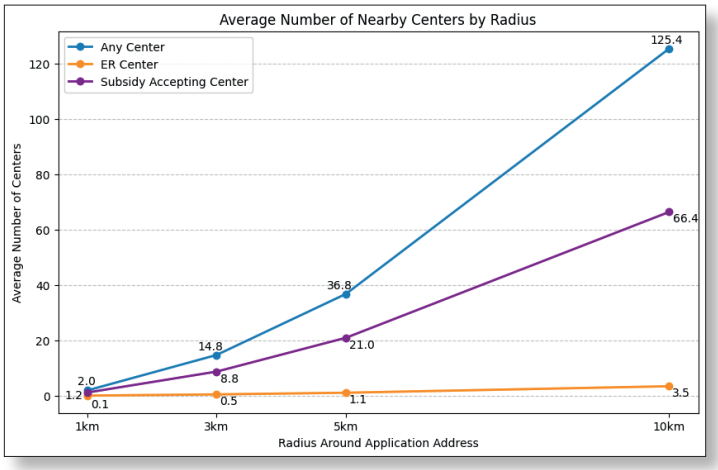
As expected based on the previous distance distribution, most families had at least one child care center within 1 km, at 77%, and nearly all families had at least one center within 3 km. But looking only at ER centers shows a different pattern. Only **8%** of families had an ER center **within 1 km (0.6 miles)**, about **41%** had one **within 3 km (1.9 mi), 66%** had at least one **within 5 km (3.1 mi)**, and **roughly 96%** had **one within 10 km (6.2 miles)**.

Figure 1.5.2



After establishing the presence of some nearby supply, we next examine the size of that supply (Figure 1.5.3). For each distance, we examine the average number of centers within the surrounding area. The figure shows these averages for all child care centers, subsidy-accepting centers, and ER centers. Here, the difference in scale between the three groups is clear. On average, families had 2 child care centers within 1 km, 15 within 3 km, 37 within 5 km, and 125 within 10 km. The average number of subsidy-accepting centers was smaller, but still relatively large, with 1.2 centers within 1 km, 8.8 within 3 km, 21 within 5 km, and 66 within 10 km. As expected, **the average number of ER centers was much smaller, with 0.1 centers within 1 km, 0.5 within 3 km, 1.1 within 5 km, and 3.5 within 10 km**. These findings demonstrate that while most families live near multiple child care centers, the number of centers that accept subsidies is more limited, and access to ER centers is even more constrained.

Figure 1.5.3

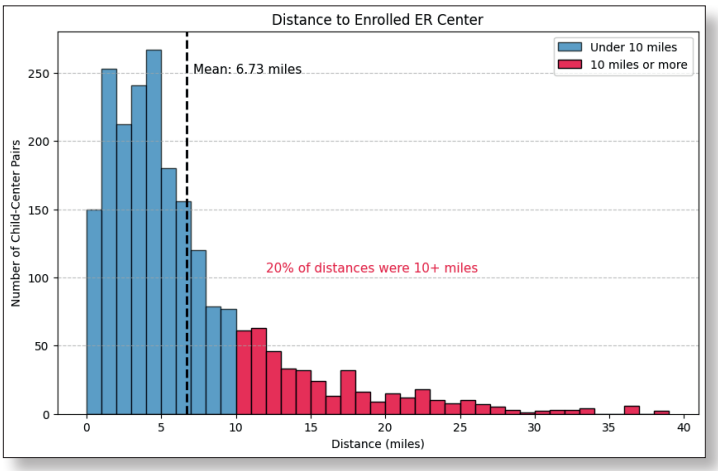


As a result, some families had to travel great distances each day, sometimes by bus (see the Harris County map in Figure 1.4.1). As one center director described: "Some of the Early REACH kids live far away, so some of the parents are actually taking 45 minutes to an hour to come here, … because there's just so many Early REACH schools and then there's just so many spaces, so if they got the space and they liked the school they're willing to do the commute. And some…don't even have transportation, so they're using the bus

system or Ubers…that becomes expensive and [time-consuming]. Maybe there's not a school where they live or maybe the school that there is is already full, so they're just having to take these slots wherever the slot becomes open." Another center director concurred: "We didn't get a lot of Early REACH kids from around here. They had a lot of kids coming from elsewhere."

To track how far families enrolled in ER were from their assigned ER centers, we merged application data with invoice payment data for enrolled children.[11] The distribution in Figure 1.5.4, which shows distances to the ER center in which a family is enrolled, makes clear that families can face barriers to accessing child care even when it is free. On average, families traveled 6.73 miles to their enrolled center. However, the distribution has a long right tail, highlighting that in one in five instances, a family traveled 10 miles or more to reach their assigned center.

Figure 1.5.4



These results may seem surprising given our earlier analysis, where we found that the nearest ER center was, on average, less than half that distance, at 2.65 miles. This raises the possibility that parents are selecting centers closer to them but ultimately enrolling in centers farther away due to capacity constraints in centers nearer to their homes. However, that does not necessarily appear to be the case, since on their applications, many parents indicate preferences for centers far from their homes. In Figure 1.5.5, we compare the distribution of enrolled center distance with the average distance to a parent's preferred center. Here, we see that enrolled distances are actually slightly more concentrated at shorter distances. Table 1.5.2 shows that the mean and median are both lower for enrolled distances. Additionally, close to 29 percent of average preferred-center distances were over 10 miles. This may be based on people selecting centers closer to their work (work proximity makes it easier for a parent to visit the center, when needed).

Figure 1.5.5

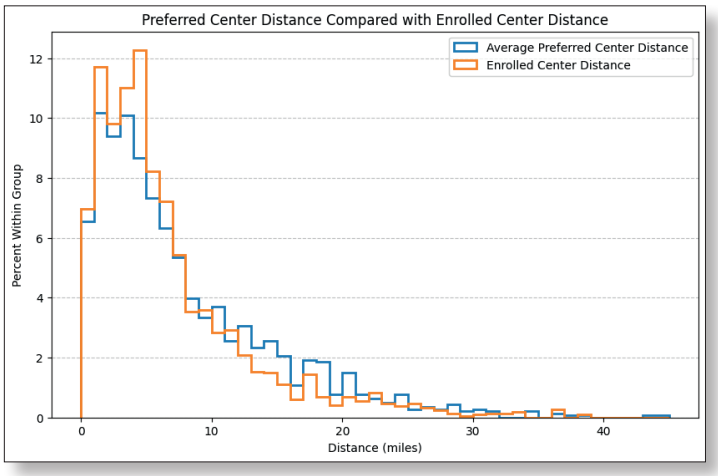


Table 1.5.2

Measure	N	Unique Application N	Mean	Median	Share 5+ miles	Share 10+ miles
Average Preferred Center Distance	1,406	1,406	7.87	5.57	55.12	28.81
Enrolled Center Distance	2,151	1,406	6.73	4.89	48.21	20.22

We will follow up with further analysis of parents' center-selection processes, based on questions related to car-ownership, parent preferences for centers close to workplace, parent interest in the reputation of a specific center, or other factors, in a later report.

Long-distance travel for some families is an unavoidable side-effect of the fact that ER is a pilot, and therefore relatively small. Were it expanded into a permanent program with substantially more slots, travel over inconvenient distance would be less of an issue. But the distance finding in itself demonstrates the usefulness of the program for families, since many are going to great lengths to access an ER center.

2. EARLY REACH INVOICING DATA

This section analyzes payment data to child care centers for ER slots. The data include payments to a center for each allotted ER slot, either as a full-month payment or as a prorated payment for less than a full month of care. In our first annual report, we focused primarily on full-month payments, which made up roughly 95% of all payments. For this report, we use full and partial month payment information to first consider the total months of payments from ER to centers. Considering partial months provides a more complete picture by accounting for payments when centers join ER mid-month or when slots are added to ER mid-month. We

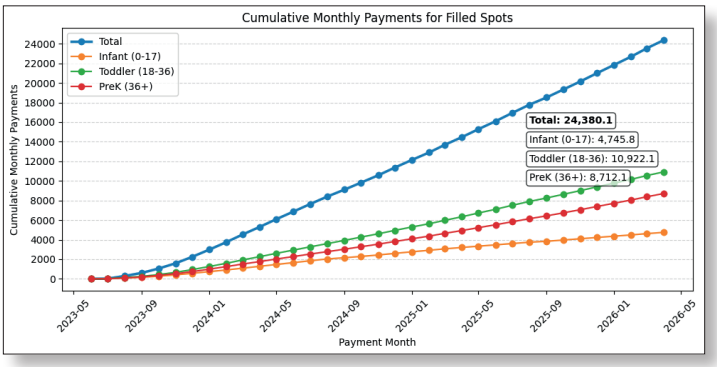
11 Because a new ER-program-data-collection system was set up after the program was already underway, some application data was spread across multiple locations, making the merge difficult. To date, we have successfully merged 2,173 child-center enrollment instances, and we are working to merge roughly 170 additional instances with their corresponding application data. The remaining instances should be fully merged for the next report.

then proceed to focus on full month payment, as we did in AR1, to analyze the portion of payments going to vacant slots.[12]

The period of analysis covers June 2023 (start of program) through April 2026. As in AR1, we define the ramp-up period as the first five months of the program, June-October 2023. The administrative complexity and cost of starting a program of this nature means that financials differ between the ramp-up period and its subsequent steady state. The longer a program lasts, the cheaper the cost of a slot overall, as the ramp up costs are spread across longer periods.

To date, we found that ER **provided an estimated 24,380.1 months of care to children in the program**. The breakdown for each age group being: 4,745.8 months of care for Infants, 10,922.1 for Toddlers, and 8,712.1 for PreK children (Figure 2.1).

Figure 2.1



As Figure 2.2 indicates, **the monthly average number of total slots was 762 (820.3, excluding ramp-up [ERU])**. The monthly average for Infants was 146 (157.7, ERU), 334 for Toddlers (364.8, ERU), and 281 for PreK (297.8, ERU).

Figure 2.2

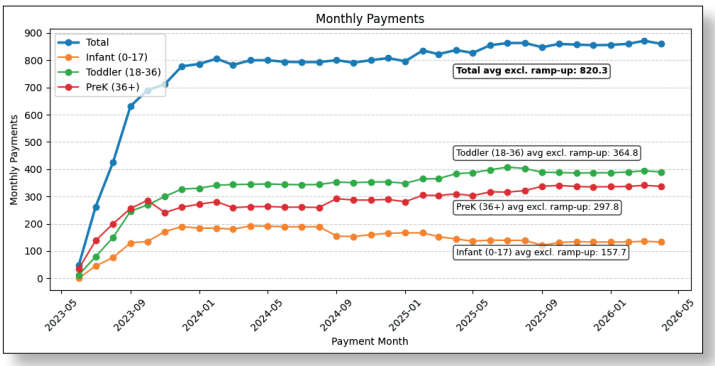


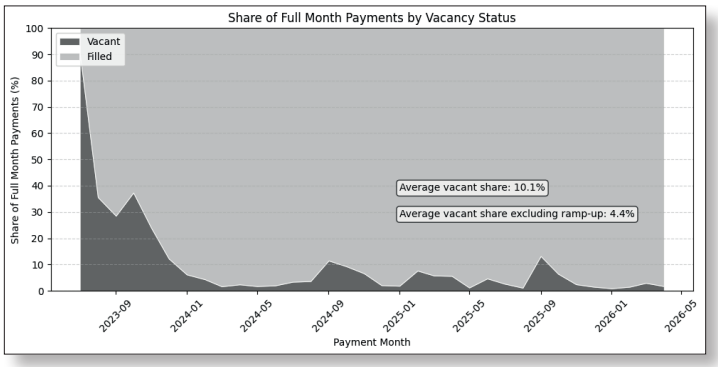
Table 2.1 shows the average number of slots for each year of the program.

Table 2.1

Average Monthly Payments by Year				
Year	Total	Infant	Toddler	PreK
2023 Ramp-Up *(June-Oct)*	411.2	77.2	151.0	183.0
2023 Excl. Ramp-Up *(Nov-Dec)*	744.8	180.2	313.7	251.0
2024	796.0	177.6	354.6	272.8
2025	843.2	142.0	384.0	317.2
2026 (Jan-April)	861.8	133.8	390.0	337.8

When including only full-month payments (for comparison with AR1), we found on average 10.1% of slots per month were vacant; however, when **excluding the ramp-up period this estimate drops to 4.4%,** in line with our AR1 finding (Figure 2.3). The periods with the most vacancies, excluding the ramp-up period, are centered around September—just after the exit of children who have aged out and when new children are in the process of enrolling.

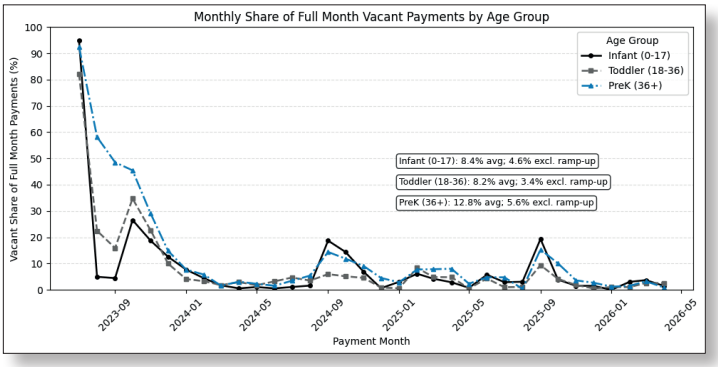
Figure 2.3



Looking at vacancies by age group provides additional insight (Figure 2.4). For full-month payments, excluding the ramp-up period (ERU), infants had an average vacancy rate of 4.6%, compared with 8.4% overall, including ramp-up. Toddlers had an average vacancy rate of 3.4% (ERU), compared with 8.2% overall. PreK children had the highest vacancy rate, at 5.6% (ERU) and 12.8% overall. One explanation of the PreK difference may be that children entering public PreK or Kindergarten in August leave before September.

12 Considering partial-payments does not have significant impacts on the share of payment going to vacant spots, because ignoring partial-payments either over- or under-count the

Figure 2.4



In addition to examining vacancies by slot count, we can also examine them in terms of dollar costs. Excluding the ramp-up period, an average of 5.2% of monthly spending on slots went toward vacant slots (13.1% when including ramp-up) (Figure 2.5). This share is higher than the share of slots that were vacant because slot costs vary by age group. Looking at just the months April 2025-April 2026, the monthly vacancy average drops to 3.5%. Over that time, as Table 2.2 shows, the program paid $15,160,968 for child care slots, of which $524,388 was for vacant slots, also representing 3.5% of total spending. The cost of a slot has effectively become less expensive over time, as slot turnover speeds up and fewer slots sit vacant.

Figure 2.5

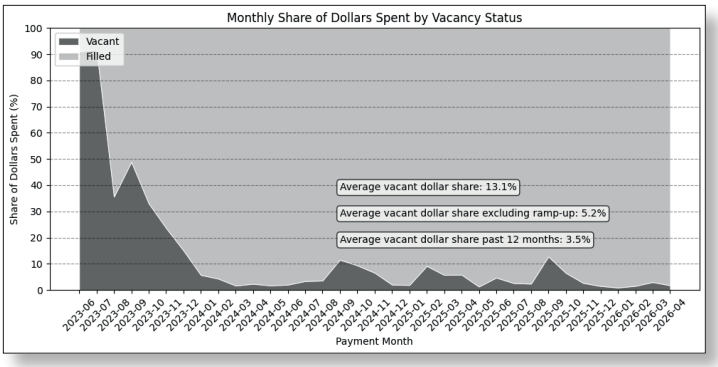


Table 2.2

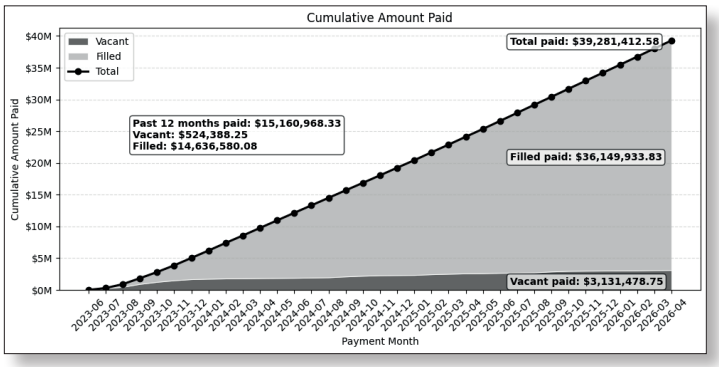
Total Amount Paid per Year by Vacancy Status

Annual payment dollars split by filled and vacant payments

Year	Total Paid	Vacant Paid	Filled Paid	Vacant Share	Filled Share
2023	**$5,034,285**	$1,689,241	$3,345,044	33.6%	66.4%
2024	**$14,208,605**	$640,342	$13,568,264	4.5%	95.5%
2025	**$14,956,469**	$710,154	$14,246,315	4.7%	95.3%
2026	**$5,082,053**	$91,742	$4,990,311	1.8%	98.2%
Past 12 months	**$15,160,968**	$524,388	$14,636,580	3.5%	96.5%

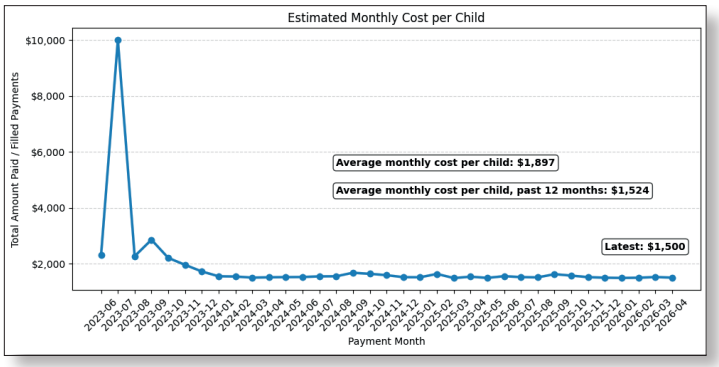
For the run of program from June 2023-April 2026, **the program paid $39,281,412 for child care slots**, of which $3,131,478 (8%) was for vacant slots. As noted earlier, vacancy payments sustain centers that would otherwise need to close or let staff go if revenue fell in the gap between students, saving the costs of restarting or rehiring. Figure 2.6 shows the amounts spent each year and their respective vacant and filled shares.

Figure 2.6



Additionally, we can examine the monthly cost per child served (Figure 2.7). This estimate was calculated by dividing total tuition payments, including payments for both filled and unfilled slots, by the number of filled slots. It does not represent total administrative or program costs. Across the full analysis period, the average tuition cost per child served was roughly $1,900. However, this average is heavily influenced by the higher vacancy rates during the ramp-up period. **Over the last twelve months of the analysis period, the average monthly tuition per child served was $1,524, and in the most recent month (April 2026), the cost per child served was $1,500**.

Figure 2.7



3. APPLICANT AND SURVEY PARTICIPANT CHARACTERISTICS

We first compare families (both ER and non-ER) who responded to the follow-up family survey with the full pool of Early REACH applicants, using all applications submitted through May 1, 2026. We also compare to our Round-1 survey respondents. Overall, Table 3.1 shows that at the time of application, Round-2 respondents look very similar to both the full applicant pool and R1 respondents across most observed characteristics. Among follow-up respondents, 96% of

actual vacant-spot payment share. As kids enroll in centers throughout the month and enroll in vacant ER spots, it averages out that there is no significant difference in the share of payment going to vacant spots whether we consider partial-month payments or not.

parents or guardians are female, 62% identify as non-Hispanic Black, 28% as Hispanic, 6% as non-Hispanic White, and 4% as another non-Hispanic race or ethnicity. These shares are nearly identical to the Round 1 respondent sample and are also close to the full applicant pool. Round 2 respondents are also similar in employment and school enrollment at the time of application: **58% were employed, average unconditional weekly work hours were 25.2 hours, and 23% were enrolled in school**. These patterns are comparable to both Round-1 respondents and the full pool of applicants.

Round 2 respondents also closely resemble the broader applicant pool in household characteristics. Their average family size was 3.22, compared with 3.17 among all applicants and 3.19 among R1 respondents. About 80% of R2 respondents reported receiving WIC or SNAP, slightly higher than the 77% among full applicants, and this difference is statistically significant at the 10% level. The main differences between R2 respondents and the full applicant pool are in application year composition. Round 1 and Round 2 respondents are both more likely to have applied in 2023 and 2024 and less likely to have applied in 2025 or 2026 compared to the full sample. This likely reflects the fact that a higher proportion of survey respondents are enrolled in ER than among the full applicant pool and ER enrollees have on average earlier application dates given the "first come, first served" feature of the slot assignment program at the start of the program. Overall, aside from small differences in public assistance receipt and application timing, follow-up respondents are broadly comparable to both R1 respondents and the full applicant pool, suggesting our sample is representative of the full applicant pool on observed baseline characteristics.

Table 3.1 Summary Statistics: Applicants vs. Baseline vs. Follow-up Respondents

	Full Applicants	Round 1 Respondents	Round 2 Respondents	Diff (Round 2 – Full)
Female (parent/guardian)	0.96 (0.19)	0.97 (0.18)	0.96 (0.19)	-0.00
NH White	0.06 (0.24)	0.05 (0.23)	0.06 (0.24)	-0.00
NH Black	0.60 (0.49)	0.60 (0.49)	0.62 (0.49)	-0.02
Hispanic	0.30 (0.46)	0.30 (0.46)	0.28 (0.45)	0.02
NH Other	0.04 (0.20)	0.04 (0.20)	0.04 (0.20)	-0.00
Employed	0.56 (0.50)	0.58 (0.49)	0.58 (0.49)	-0.02
Weekly work hours (unconditional)	24.41 (18.38)	24.34 (18.16)	25.21 (17.65)	-0.79
Enrolled in school	0.23 (0.42)	0.23 (0.42)	0.23 (0.42)	0.00
Receiving WIC or SNAP	0.77 (0.42)	0.80 (0.40)	0.80 (0.40)	-0.03*
Homeless at application	0.05 (0.22)	0.05 (0.21)	0.05 (0.21)	0.00
Family size	3.17 (1.32)	3.19 (1.36)	3.22 (1.36)	-0.05
App year: 2023	0.38 (0.49)	0.33 (0.47)	0.41 (0.49)	-0.03
App year: 2024	0.25 (0.43)	0.45 (0.50)	0.37 (0.48)	-0.11***
App year: 2025	0.31 (0.46)	0.22 (0.41)	0.22 (0.42)	0.09***
App year: 2026	0.06 (0.23)	0.00 (0.00)	0.00 (0.00)	0.06***
N	4,497	927	1,104	

*Cells report mean and (standard deviation). Diff = mean (Follow-up respondents) - mean (Full applicants) from two-sample t-test; p-value in parentheses. Stars: * p<0.10 ** p<0.05 *** p<0.01.*

4. EFFECTS OF EARLY REACH ON PRIMARY CAREGIVERS' EMPLOYMENT

4.1 Participating vs. non-Participating PCs' Employment Status

Round 2 of the family survey asked about primary caregivers' employment status in four years (2022, 2023, 2024, and 2025). To study the effect of the Early REACH program on respondents' employment, we merge the survey data with the enrollment data from Baker Ripley, which includes records of ER children's enrollment start and end dates. The resulting analytic sample of observations per primary caregiver [PC] per year (N= 2936, with 744 unique PCs) allows us to follow each person's employment trajectory over the four-year window and to compare changes across families that did or did not enroll in the program.[13]

PCs participating in ER and those not participating are similar across many demographic and household characteristics, as reported in Appendix Table 1. In the full sample, 93% of PCs are mothers, and about 17% are married. In terms of race and ethnicity, 62% are non-Hispanic Black, 26% are Hispanic, 7% are non-Hispanic White, and 5% are non-Hispanic Asian/Pacific Islander/Other. About 6% have some high school or less, 28% have a high school education or equivalent, 47% have some college or an associate's degree, and 17% hold a bachelor's degree or higher. The average household size is 3.18, 60% receive Medicaid, 47% receive Food Stamps, 46% receive WIC, and 43% are eligible for the Earned Income Tax Credit.

Although the two groups are broadly similar on many baseline characteristics, they differ on several household and program-related measures. ER families have slightly larger households, with an average household size of 3.33 compared with 3.07 among non-ER families, and they have more young children on average: 1.72 compared with 1.36. ER families are also less likely to receive Food Stamps (42% compared with 50%), and less likely to have had a child in daycare in 2022–23 (29% compared with 43%). The two groups also differ in timing of application to the program: 59% of ER families applied in 2023 compared with 31% of non-ER families, while 10% of ER families applied in 2025 compared with 36% of non-ER families.

Overall, the two groups are similar on many baseline demographic characteristics, though some household composition and program-timing differences remain. Among eligible applicants, selection into ER is jointly determined by application timing, the availability of slots among PC-preferred centers, and prioritization by Baker Ripley based on applicant characteristics. Differences in ER and non-ER respondents' characteristics reflect both non-random selection into ER and potentially also differential response rates to the survey. Given the selection concerns, in addition to providing descriptive comparisons of employment transition probabilities, we also conduct difference-in-differences based analysis to help control for pre-existing observable and unobservable differences between ER and non-ER PCs in analyzing ER employment effects.

4.2 Effects on Transition, Retention, and Overall Employment, Utilizing Two Approaches

4.2.1 Transition to employment

In our first report, we compared the respondents' current reported employment status to their employment status stated in their application. In this second report (AR2), instead of the application data (which may not reflect status just prior to entry into the ER program if some time passed before they were enrolled), we ask them what their employment status was in the year prior to admission into ER and use that response for the comparison to the later years.

In AR1 we looked descriptively at the raw or unadjusted rates for parents transitioning into employment, so for comparison we offer an analysis here also of the descriptive rates from Round 2 of the survey below. We follow that with an analysis that exploits the additional information in the Round 2 survey to control for differences in timing and other characteristics between ER and non-ER PCs, to help isolate the effects of ER on employment from spurious differences due to non-random selection into ER.

Unadjusted transition rate

Among PCs who were not employed in 2022, the unadjusted transition rates show that ER PCs were more likely than non-ER PCs to move into employment after the program began. By the 2025 follow-up, **67.5%** of ER PCs **who were not employed in 2022 had become employed**, compared with 41.2% of non-ER PCs, an unadjusted **difference of 26.3 percentage points**. Put differently, the 2025 employment transition rate among ER PCs was about 64% higher than among non-ER PCs. This is substantially larger than the 37.1% increase in employment found in AR1, suggesting that the updated sample shows an even stronger pattern of employment gains among initially non-employed PCs.

Adjusted transition rate

Because families enrolled in ER at different points in time, we next estimate program effects using a staggered difference-in-differences approach following Callaway and Sant'Anna (2021). The difference-in-differences method is a widely used policy evaluation approach that isolates the effect of a program. This method compares changes across time in outcomes for families after they enter ER with changes across time over the same specific years for families that never enter the program.

When we then control for differences in enrollment timing and observable family characteristics,[14] the difference-in-differences estimate shows that ER increased the probability of transitioning from unemployment into employment by **24.0 percentage points** (Table 4.2.1 column A) relative to comparable families who never enrolled in ER. Considering the average ER and non-ER PCs,

13 The analysis sample is smaller than the total number of survey responses for two reasons. First, we exclude non-ER families who are not comparable to ER families, including applicants whose application status was recorded as ineligible. Second, we restrict the sample to observations with non-missing values for key analysis variables, such as employment status and child enrollment date.

14 We include the following family characteristics: number of children 0-5, PC's race-ethnicity, education and marital status.

this means there is a **57.5% increase in the unemployment-to-employment transition for ER compared to non-ER** PCs. This suggests that free child care access may be especially important for unemployed PCs in providing the opportunity to enter (or re-enter) into employment. By providing subsidized full-time care, ER may make it easier for these PCs to look for work, attend interviews, participate in training or education, and accept jobs with regular or less flexible schedules.

Both unadjusted comparisons and the adjusted (regression-based) estimates stated above show a larger effect than we found in AR1, for at least two reasons:

- the likelihood that parents will find work increases with their length of time in the program (a duration effect of child care).
- using the enrollment date provides a more precise measure of when PCs begin receiving treatment, compared with using the application date in AR1.

Table 4.2.1 Regression-Adjusted ER Effects on Employment Outcomes

Employment	(A) Transition	(B) Retention	(C) Overall
ER effect	0.240*** (0.062)	0.081*** (0.021)	0.148*** (0.029)
Observations (person-year)	723	2185	2936
N (ER primary caregivers)	80	212	297
N (Non-ER primary caregivers)	102	339	447

*Standard errors in parentheses; * p<.10, ** p<.05, *** p<.01.*

4.2.2 Retention of employment

In the previous report, we examined employment retention among PCs who were already working before the program and did not find a clear effect. Here we reexamine this outcome using additional years of employment data. Among respondents who were employed in 2022 (before ER began), the raw/unadjusted retention rates show that ER PCs were more likely than non-ER PCs to remain employed through the follow-up period. By 2025, 83.5% of ER PCs who were employed in 2022 were still employed, compared with 71.1% of non-ER PCs who were employed in 2022, an unadjusted difference of 12.4 percentage points. Put differently, the 2025 employment retention rate among ER PCs was about 17% higher than among non-ER PCs.

However, the unadjusted analysis does not account for the fact that some ER PCs joined the program later than others, or other factors. When we adjust for differences in enrollment timing and observable family characteristics, the estimated effect remains positive, though lower. As reported in Table 4.2.1 column B, **ER increased the probability of remaining employed by 8.1 percentage points**, relative to comparable families who never enrolled in ER. This is an **11% increase** to the job retention rate for ER compared to non-ER PCs. This estimate is statistically significant.

4.2.3 Overall employment

Lastly, in this report we also examine the overall effect on employment for all families in the sample—both those who were employed and those who were not employed in 2022. Table 4.2.1 column C reports the estimated effect of ER on PCs' **overall employment using the same difference-in-differences approach. The estimate shows that ER increased overall primary caregiver employment by 14.8 percentage points, relative to families who never enrolled in ER (non-ER employment declined** over the same period). This estimate is statistically significant.

Taken together, these results suggest that ER supports PC employment through two related margins. First, among PCs who were not employed before entering the program, ER appears to increase transitions into employment by reducing a major barrier to job search and labor force. Second, ER assists those PCs who are already employed on entry as well as those who become employed after, by lowering costs for their family, giving children access to high-quality care, and providing them with a higher likelihood of continued employment.

4.3 Employment Effects by Time Since Enrollment

The regression-based estimates in Section 4.2 summarize the average effect of ER across all participating families, but they pool together families regardless of how long they have been enrolled in the program. By the 2025 survey, families who enrolled in 2023 could have had more than two years of access to ER child care, while families who enrolled in 2025 may have had only a few months. **Knowing how the effect evolves with time in the program is important for policy**: parents typically need time to search for work, complete training, increase hours, and/or stabilize in a new job after gaining access to child care, so the employment response may build gradually rather than appear immediately upon enrollment. If most of the effect emerges only after a year or more in the program, a single pooled estimate could understate the program's true benefits and mask the dynamics that matter most for understanding how subsidized child care affects parental employment over time.

To trace how ER's effect evolves with time in the program, we estimate an event study version of the same difference-in-differences approach developed by Callaway and Sant'Anna (2021). The event study version separately estimates the effect of ER in each period before and after enrollment—for example, how employment changes in the first 12 months after enrollment, the next 12 months, and so on—by comparing the change in employment among ER families with the change over the same calendar period among comparable families who never enrolled, while controlling for observable family differences. The key identifying assumption is parallel trends: without ER, participating families in each analysis group would have experienced similar changes in employment outcomes over time as comparable families who did not receive an ER slot. We assess this assumption by examining the estimated differences between ER and comparison families in the periods before enrollment; pre-enrollment differences that are small and statistically

indistinguishable from zero lend support to the assumption that trajectories would be otherwise similar.

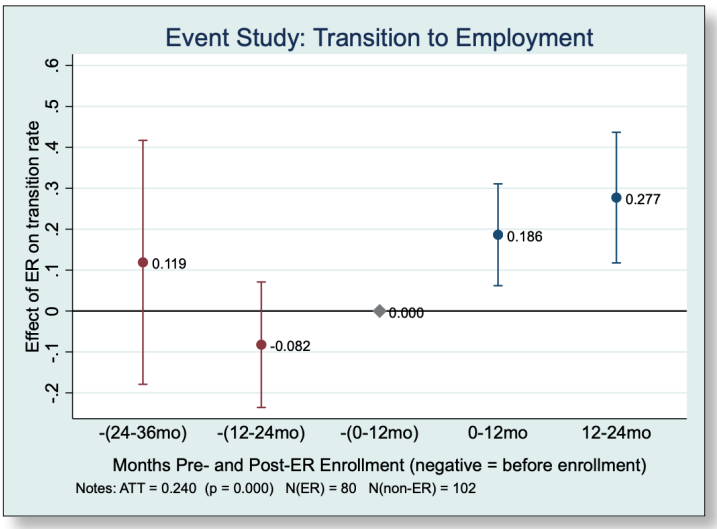
Our analytic sample includes 130 ER families who joined the program in 2023, 113 who joined in 2024, and 54 who joined in 2025, providing the variation in enrollment cohort and length of exposure that we use to estimate how the effect varies with time in the program.

The following subsection reports the event-study results in the same outcome order: transitions into employment, retention of employment, and overall employment.

4.3.1 Transition to employment

We first examine how the transition effect changes with time in the program. As shown in Figure 4.3.1, during the first 12 months after enrollment, ER increased the probability of transitioning into employment by **18.6 percentage points**. After families had been enrolled for 12 to 24 months, the estimated effect **rose to 27.7 percentage points**. Both estimates are statistically significant. Before enrollment, the estimated differences between ER and comparison families are not statistically significant, which provides some support for the assumption that the two groups would have followed similar employment trends in the absence of ER.

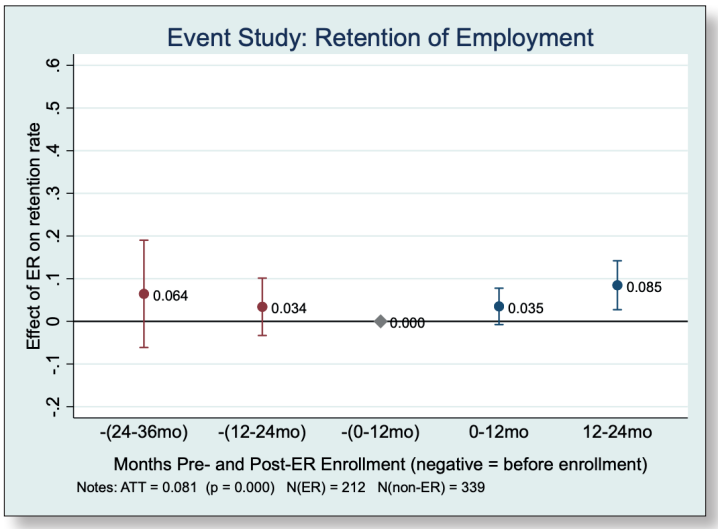
Figure 4.3.1



4.3.2 Retention of employment

We then examine whether the retention effect changes with time in the program. As shown in Figure 4.3.2, during the first 12 months after enrollment, the estimated effect is **3.5 percentage points**, but it is not statistically significant. After families had been enrolled for 12 to 24 months, the estimated effect **rose to 8.5 percentage points** and is statistically significant. The retention results suggest that ER may also help PCs who are already employed remain attached to the labor market. This effect may be less immediate than the transition effect because employed PCs may already have other care arrangements in place (perhaps with family), but over time, paid child care may help prevent job loss caused by instability in the other care arrangements.

Figure 4.3.2



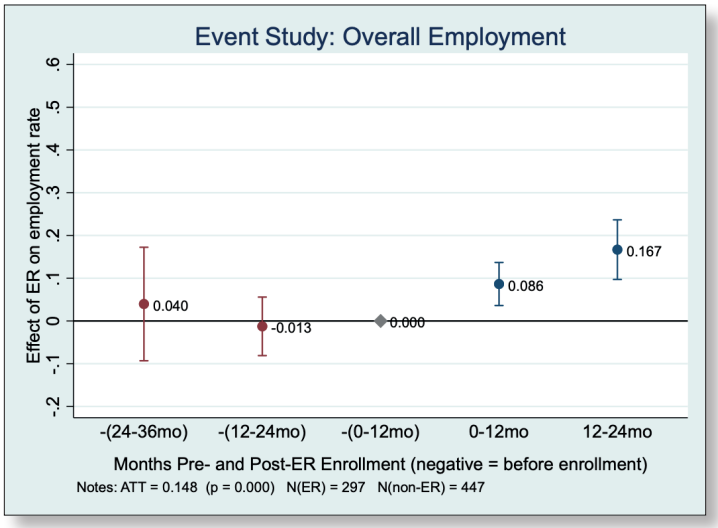
4.3.3 Overall employment

As shown in Figure 4.3.3, the overall employment effect also grows over time. **During the first 12 months** after enrollment, **ER increased primary caregiver employment by 8.6 percentage points**. After families had been enrolled for **12 to 24 months**, the estimated effect **rose to 16.7 percentage points**. Both estimates are statistically significant. The results suggest that **ER increased overall PC employment**, with larger effects emerging after families had been enrolled for at least one year.

These findings are consistent with the idea that employment responses take time. After receiving child care support, PCs may need several months or more to search for work, find jobs that match their schedule, increase hours, or stabilize employment.

In our next report, we will explore how employment is affected when children graduate and their parents no longer have full-time child care support through ER.

Figure 4.3.3



5. PARTICIPATING VS. NON-PARTICIPATING CENTERS

The total number of Early REACH (ER) slots filled varied from month to month and from year to year. Figure 5.1 below shows the maximum monthly slots filled in each year in the Early REACH program as a whole (based on payment data).

Table 5.1

Year	Year and Month	Maximum Monthly Filled Slots
2023	2023-12	652
2024	2024-12	790
2025	2025-12	842
2026	2026-01	848

Between June 2023 and April 2026, the total number of filled monthly slots (including partial months) has been 24,380.1, with roughly 1900 children served. The overall monthly average for the life of the program to that point is 762 (820, excluding the ramp-up period).

We conducted the Round 2 survey of both child care centers participating in the ER program and non-ER centers in the vicinity of ER centers, in Spring 2026. Of the 167 centers that responded, 26 currently participate in ER and 141 are non-ER centers (half TRS-rated and half not). Six of the 8 ER centers that did not respond had already exited the program, and 2 were new entrants. This represents a 76.5% response rate among the 34 centers that have participated in Early REACH over the program's existence, and a 92.9% response rate among the 28 ER centers active at the time of the survey. All 4 ER centers surveyed only in Round 1 had exited ER by the time of the Round 2 survey.[15]

5.1 Slots analysis

Framework

Centers are contracted by ER for a subset of their total available slots. Each center has at least three sets of slots at any given time: total licensed capacity (determined by square footage, but not necessarily all built out to serve children), total available slots (a subset of licensed capacity, determined by build out and staffing), total filled slots (determined by children signed up)—some of those filled slots funded by ER, others not. And if not all slots are full, there is a fourth set, of vacant slots.

While the goal of the program was to increase the availability of affordable slots in underserved areas, it was **to be determined if centers would find it most effective to add new slots** to their total stock of filled slots, maintain the same number of slots and **substitute ER funding for funding from other sources**, or some **combination of both**. Any of these options would accomplish the goal. The facts that the ER program was known to be a pilot with a limited span, and that its initial phase involved a lot of internal changes to centers (in teaching methodology, business methods, new equipment, etc.), were likely to impact owners'/directors' decisions about whether/how much to invest in expanding the total number of slots in this phase.

While on the one hand expansion could mean serving more children, and potentially more profit, on the other hand, if they expanded their number of slots and staffing that would mean more supervisory work, for which not all small businesses are prepared. And centers could anticipate that when ER ended, they might need to let staff go and reduce or reorganize their space, losing any investment, if they couldn't easily fill the new slots with new children. That could be the case if the number of slots subsidized by the Texas Workforce Commission in the region did not expand and they no longer had the benefit of ER to funnel children into their center rather than others. Thus, it could be unclear whether the investment in expanding the number of slots would be worth the short-term return. If the program were made more long term, and they could expect a continued steady stream of guaranteed customers, centers might be more likely to invest more in expansion over time.

While ER centers had the advantage that ER parents had to fill their slots while the program operated, post-ER the centers may be disadvantaged if they suddenly have many empty slots and they have to compete to fill their slots with the non-ER centers. Former ER parents who get a a portable child care subsidy through Workforce Solutions, the Texas Education Freedom Act (TEFA - aka the Voucher program),[16] or another source or who can self-pay (very few) will be free to go to other centers (to decrease travel distance or for other reasons). Those parents who get no new subsidy will also leave (except in those cases where centers themselves offer scholarships).[17] Such exits may leave ER centers with empty slots to fill (in some cases many), in direct competition with the other centers near them, who may not have as many openings.

Anticipation of this dynamic seems to have shaped at least some center directors' thinking about whether to expand their total slots during ER. As one director put it, "If we'd known it was going to be an ongoing program – yeah, we would have expanded – we would have expanded greatly. But because we knew – rather be safe than sorry, you stay grounded. Like I do know a lot of centers that expanded. And I'm like 'Y'all know this is a pilot program – it's not [long-term] like NCI [Workforce Solutions].'"

In the following analysis, we will present results from ER and non-ER center surveys. The findings document changes to ER centers over the course of the program in child enrollment and staffing patterns. The comparison to non-ER centers provides a point of contrast for alternative trajectories of outcomes in the

15 The samples of centers differ between Round 1 and Round 2, which may lead to differences between the statistics reported here compared to our AR1, even for the same reference year. In Round 1, 131 unique centers responded, while 167 centers responded in Round 2. Ninety-two centers responded in both rounds, representing 70.2 percent of the Round 1 sample and 62.6 percent of the Round 2 sample. The overlap includes 69 non-ER centers and 23 ER centers. As a result, changes in reported averages for same period across AR1 and AR2 may reflect changes in the composition of the responding centers.

16 This new funding program begins operation in mid-August 2026, at roughly the time Early REACH is phasing out. Some ER centers have been approved for TEFA, and will be able to fill some of their vacancies that way.

17 At least one center reported covering some needy families' costs (in their case for 10 families per year).

absence of ER. Our analysis in this section is descriptive. Due to selection effects for centers in the ER program and for the non-ER centers that respond to the surveys, as well as potential local spillover impacts of ER into neighboring non-ER centers, we do not interpret the comparisons of ER and non-ER centers as showing the causal effects of the policy.[18]

Subsample Analysis

We first examine the slot situation for ER centers, focusing on the total number of children they served and how this breaks out by ER and non-ER slots. **For this section, we restrict the ER-center analysis to a subsample of 17 centers**. This includes centers that enrolled in 2023, ensuring that all statistics reported for ER centers in 2023 and later reflect centers that were already participating in the ER program. Among the 26 ER centers in the survey response sample, 20 were enrolled in 2023. Three of these 20 centers did not provide complete responses and were excluded, leaving a final ER-center analysis sample of 17 centers. Though these numbers are not directly comparable to the data in the earlier sections based on full administrative payment data, and there is variation across centers, the findings from the subsample should provide a helpful initial sense of the patterns in play for the larger group of ER centers. We will examine these trends further in later reports.

In the survey, both ER and non-ER centers were asked how many children they served or are currently serving in each age group — infant, toddler, and preschool — for each school year between 2022–23 and 2025–26. As a group, the 17 ER centers in the subsample served an **average of 800 children per year** from 2023-2026, averaging 127.5 infants, 307.5 toddlers, and 365 preschool children (Table 5.1.1), **in both ER slots and non-ER slots**. Total enrollment in these 17 ER centers increased from 697 children in school year 2022–23 to 736 in 2023–24, to 896 in 2024–25, and then decreased slightly to 871 in 2025–26 (though the data reported in the Round 2 survey only covered the first four months of that year).

Table 5.1.1 ER Centers — Total Served Slots (ER and non-ER slots)

Slot Type	2022-23	2023-24	2024-25	2025-26	Total	Yearly Average
Infant	113	118	148	131	510	127.5
Toddler	247	253	360	370	1,230	307.5
Pre-school	337	365	388	370	1,460	365.0
Total	**697**	**736**	**896**	**871**	**3,200**	**800.0**

Overall, the number of children served each year during the ER period was higher than the 2022-23 level, substantially so in 2024-25 and 2025-26. Relative to the ramp-up period in school year 2022-2023, total enrollment increased by 5.6% in school year 2023–24, 28.6% in 2024–25, and 25% in 2025–26 (Table 5.1.2).

Table 5.1.2 ER Centers — Aggregate growth rate of total served slots vs. 2022-23 school year

Slot Type	2023-24	2024-25	2025-26
Infant	4.4%	31.0%	15.9%
Toddler	2.4%	45.7%	49.8%
Preschool	8.3%	15.1%	9.8%
Total	**5.6%**	**28.6%**	**25.0%**

We next examine the number of filled ER slots among these 17 centers. As shown in Table 5.1.3, across 2023–24 to 2025–26, the 17 ER centers filled a total of 1,733 ER slots, **averaging 577.7 filled ER slots per year**. By age group, toddler and preschool slots accounted for the largest shares of filled ER slots. Centers filled an average of 236 toddler ER slots and 245.7 preschool ER slots per year, compared with 96 infant ER slots per year. The lower number of infants might be due to parents keeping young children at home and/or to the length of the wait in the queue for the subsidy.

Over time, the total number of filled ER slots remained relatively stable, with 578 filled slots in 2023–24 and 567 in 2025–26. This overall stability masks different trends by age group. Filled toddler slots increased from 214 in 2023–24 to 256 in 2025–26. In contrast, filled infant slots declined from 110 in 2023–24 to 95 in 2024–25 and 83 in 2025–26. Filled preschool slots remained stable between 2023–24 and 2024–25, at around 254 slots, before declining to 228 in 2025–26. (Again, since the Round 2 survey covered only the first four months of the 2025–26 school year, the decline in filled infant and preschool slots in 2025–26 should be noted but interpreted with caution.)

Table 5.1.3 ER Centers — Total filled ER slots

Slot Type	2023-24	2024-25	2025-26	Total	Yearly Average
Infant	110	95	83	288	96
Toddler	214	238	256	708	236
Preschool	254	255	228	737	245.7
Total	**578**	**588**	**567**	**1,733**	**577.7**

Next we calculate the non-ER slots in the subsample by subtracting filled ER slots from total served slots. In 2022–23, before the ER program launched, all served slots are classified as non-ER slots. Table 5.1.4 presents the number of non-ER slots among ER centers before and after the program launched, from the 2022-23 pre-launch baseline through 2025-26. Non-ER slots were relatively low in the infant and toddler categories in 2023–24, as the ER program phased in, but increased substantially in 2024–25 and remained higher in 2025–26.

18 The differences in patterns across time between ER and non-ER centers could plausibly be driven by factors unrelated to ER implementation. The ER program selected into program centers that applied to the ER center pool, that met ER center eligibility criteria, and that were further selected by ER administrators. Furthermore, our non-ER sample is selected based on the willingness of directors to respond to our survey. These layers of selection into our ER and non-ER analysis samples mean that ER centers differ from non-ER centers based on observed characteristics but also unobserved characteristics including center leadership capacity. Given these, it is plausible that in the absence of ER, ER centers would have experienced a different path of changes in enrollment and staff patterns compared to what is shown for our non-ER sample.

Table 5.1.4 ER Centers — Total filled non-ER slots before and after ER launch

Slot Type	2022–23 (pre ER)	2023–24	2024–25	2025–26	Total	Yearly Average
Infant	113	8	53	48	222	55.5
Toddler	247	39	122	114	522	130.5
Preschool	337	111	133	142	723	180.8
Total	**697**	**158**	**308**	**304**	**1,467**	**366.8**

ER slots represented a large share of these centers' overall enrollment on a yearly average basis. Comparing the average annual number of filled ER slots in Table 5.1.3 with the corresponding three-year average annual number of total children served in Table 5.1.1, **filled ER slots accounted for about 69.2% of all children served by the 17 ER centers**. This share was **highest in 2023–24**, when the ER program first launched, with filled ER slots accounting for **78.5%** of all children served by these centers. The share then declined to **65.6% in 2024–25** and remained relatively stable at **65.1% in 2025–26**. The overall average share of 69.2% also masks substantial heterogeneity across centers. At the center level, the share of filled ER slots in children served ranged from 22.5% to 92.4%. We will look in more depth into the variation across centers with high and low shares of ER slots in the next report, and the effect of the variation on ramp-down.

The results above show that these 17 ER centers experienced positive growth in total children served after the ER program launched, and that ER slots accounted for a large share of their overall enrollment. In what follows we examine the pattern of change in the number and status of slots over time, calculating the change in total children served relative to the 2022–23 baseline and comparing that change with the number of ER slots filled in each year. This comparison should not be interpreted as causal, since enrollment may also change because of local demand, staffing levels, licensing capacity, or other center-level factors. Additionally, in some cases centers were asked to expand their number of slots by Early REACH, to meet demand while limiting administrative costs. However, it provides a useful accounting benchmark for assessing how much of the ER enrollment represented net growth in center enrollment and available slots versus a direct conversion of non-ER into ER-funded slots.

At the aggregate level, the increase in total children served was substantial, but smaller than the number of filled ER slots. Across all age groups, **the 17 ER centers in the subsample served 697 children in 2022-23**. With the expansion of ER, they **served 39 more children in 2023–24, 199 more children in 2024–25, and 174 more children in 2025–26** relative to the 2022–23 baseline. Contrasting this with the 578, 588, and 567 ER slots filled in these centers over these same years, **the increase in children** served as a share of filled ER slots in this sample represented **an addition of 6.7% of the filled ER slots in 2023–24, 33.8% in 2024–25, and 30.7% in 2025–26**. Thus, while filled ER slots were accompanied by some increases in total enrollment, especially in 2024–25, those increases in enrollment were substantially smaller than the number of ER slots filled. This indicates that most of the ER slots took over pre-existent slots, rather than involving major expansions of the total number of slots each center offered. Thus, overall, the ER centers chose the route of some but not extensive expansion of the total number of slots, during the ER pilot, though the approach taken by individual centers varied widely.

At the center level, the relationship between change in total children served and added ER slots varied widely. Thirteen of the 17 ER centers served more children on average after ER implementation than they had served in 2022–23, while four centers served fewer children. The size of the increase also differed widely: the average change in total children served as a share of filled ER slots ranged from a decline of 33.3% to an increase of 148.4%. This suggests that the aggregate pattern was not driven by uniform expansion across all centers. Instead, some centers expanded total enrollment substantially, while others used ER slots primarily to support or replace existing enrollment rather than to increase the total number of children served.

There could be multiple reasons why the increase in total children served was smaller than the number of filled ER slots. Among them: some ER-funded slots **were filled by students previously enrolled in their center**, rather than representing entirely new children served. In that situation, ER would still affect centers by changing the funding source for children already enrolled and by improving affordability and revenue stability, even if enrollment did not increase one-for-one. ER may have also helped stabilize enrollment by **preventing declines** that might otherwise have occurred, an effect that would not be captured by comparing enrollment only to the pre-ER baseline. This seems possible, given that some centers had empty slots at the time of entry into ER. Additionally, centers may have wished to protect themselves by not investing too much in build-out when they knew the ER program was of limited length, after which they would need to fill their empty slots in a challenging environment. And there may be other reasons as well.

We next examine the slot situation among non-ER centers. For this analysis, we restrict the sample to 92 non-ER centers that provided complete responses on the number of children served across all years and age groups. As shown in Table 5.1.5, as a group these centers served an average of 3,743 children per year across 2022–23 to 2025–26, including 667 infants, 1,207 toddlers, and 1,869 preschool children. Total enrollment among these centers was relatively stable over time, increasing slightly from 3,603 children in 2022–23 to 3,700 in 2025–26. The growth rates in Table 5.1.6 confirm that non-ER centers experienced modest and less sustained enrollment growth than the ER centers. Among non-ER centers, total enrollment increased by 2.7% in 2023–24 and 10.2% in 2024–25 relative to 2022–23, but returned to 2.7% in 2025–26.

The contrast between ER and non-ER centers is strongest in 2025–26. **Total enrollment at ER centers grew about 25% above their 2022–23 baseline, versus about 2.7% at non-ER centers**. This difference was especially pronounced for toddlers: ER centers had toddler enrollment growth of 49.8% in 2025–26, versus 5.1% among non-ER centers. The descriptive pattern is consistent with the hypothesis that ER participation helped centers expand or sustain the number of children served, particularly among toddlers. But given that ER centers may differ in profile from non-ER centers,

it is plausible that in the absence of ER, ER centers would have experienced a different path of changes in enrollment compared to what is shown for our non-ER sample.

Table 5.1.5 Non-ER Centers — Total served slots

Slot Type	2022-23	2023-24	2024-25	2025-26	Total	Aver-age
Infant	649	654	727	638	2,668	667.0
Toddler	1,151	1,185	1,282	1,210	4,828	1,207.0
Preschool	1,803	1,862	1,960	1,852	7,477	1,869.2
Total	**3,603**	**3,701**	**3,969**	**3,700**	**14,973**	**3,743.2**

Table 5.1.6 Non-ER Centers — Aggregate growth rate of total served slots vs. 2022-23

Slot Type	2023-24	2024-25	2025-26
Infant	0.8%	12.0%	-1.7%
Toddler	3.0%	11.4%	5.1%
Preschool	3.3%	8.7%	2.7%
Total	**2.7%**	**10.2%**	**2.7%**

5.2 Staffing Patterns

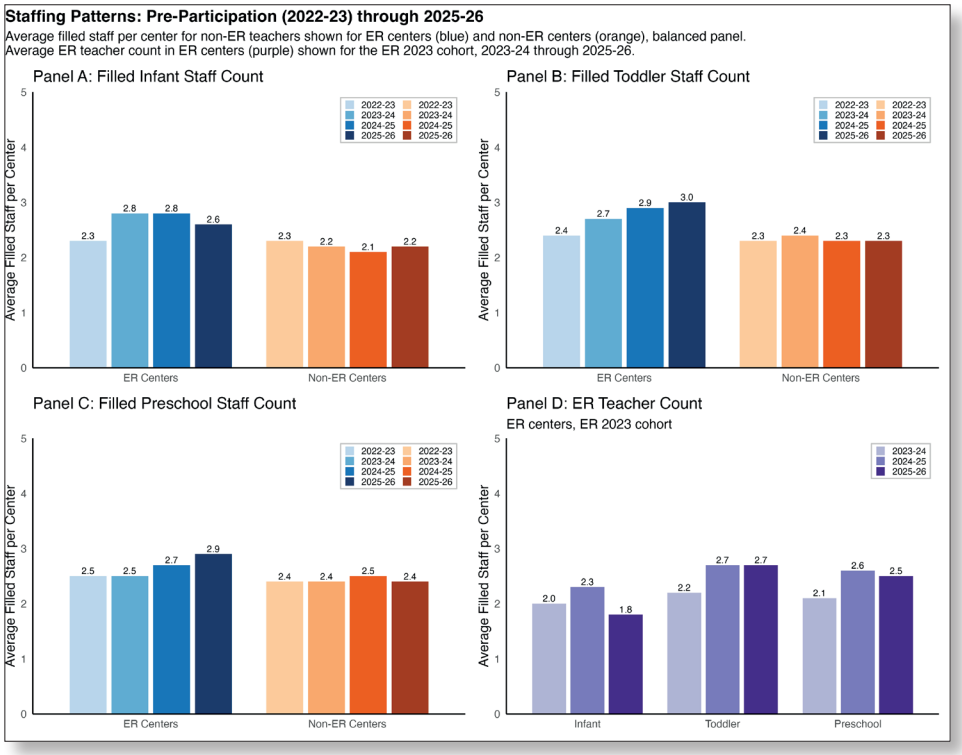
In this section, we follow the same structure as in AR1 to examine staffing patterns. In AR1, we found that ER centers experienced larger staffing increases than non-ER centers through 2024–25. The Round 2 survey allows us to revisit this finding with an additional year of data and assess whether the pattern continued in 2025–26.[19]

Panels A-C of Figure 5.1 report the number of filled teacher positions for each service type over time. The Round 2 **results continue to show that ER centers had higher staffing levels than non-ER centers in 2025–26**.

Among non-ER teachers, ER centers continued to report higher filled staffing levels than non-ER centers in 2025–26: 2.6 versus 2.2 infant teachers, 3.0 versus 2.3 toddler teachers, and 2.9 versus 2.4 preschool teachers. Relative to 2024–25, infant staffing in ER centers declined slightly, while toddler and preschool staffing continued to increase.

ER centers designate teaching staff as Early REACH teachers, but they vary in how they do it. Some centers classify all teachers as ER teachers, while others apply a more targeted definition by designating only specific staff. Among the 26 surveyed ER centers that reported this information, 13 classified all teachers as ER teachers, while 13 used a targeted designation. Panel D of Figure 5.1 reports the number of designated ER teachers in ER centers. The number of designated ER teachers also remained broadly stable for toddler and preschool but declined for infant in 2025–26.

Figure 5.1

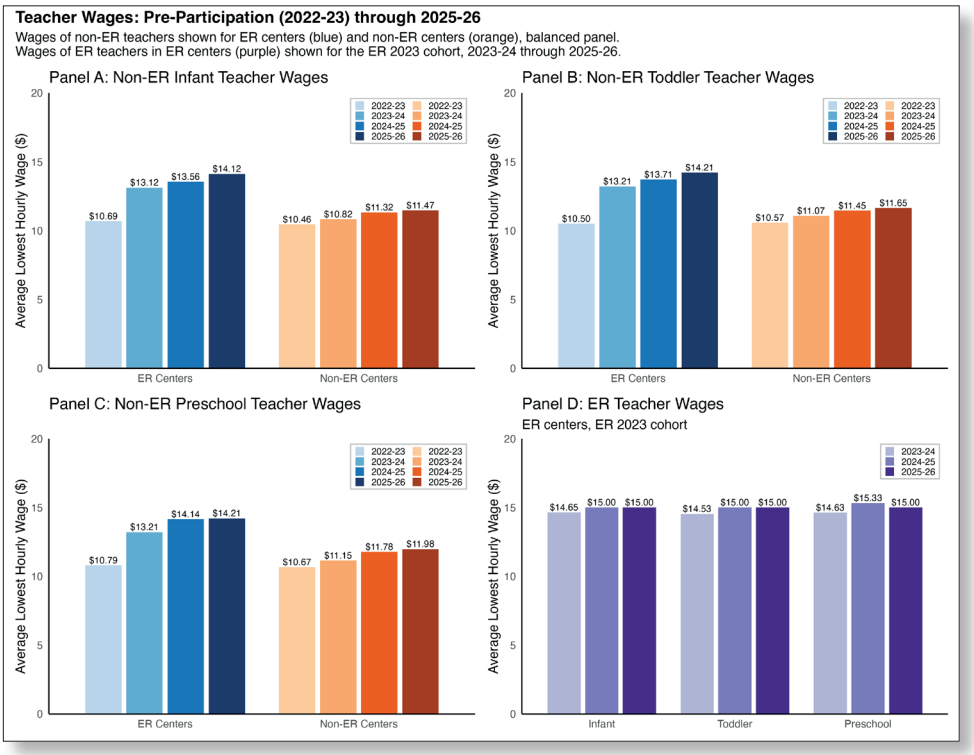


5.3 Wage comparison among ER and non-ER Teachers

In AR1, we found that ER centers largely complied with the program's $15/hour wage requirement and that wage gains appeared to extend beyond designated ER classrooms. The updated wage results show that these patterns persisted into 2025–26. As shown in Figure 5.2 Panel A to C, among non-ER teachers, average low-end wages remained higher in ER centers than in non-ER centers: $14.12 versus $11.47 for infant teachers, $14.21 versus $11.65 for toddler teachers, and $14.21 versus $11.98 for preschool teachers. In Panel D of Figure 5.2, wages for designated ER teachers also remained close to the program's $15/hour requirement in 2025–26, with average low-end wages of $15.00 for infant, toddler, and preschool teachers. Overall, these results suggest continued adherence to the ER wage policy and sustained wage differences between ER and non-ER centers.

19 Because the Round 2 analysis uses a different balanced sample than AR1, values reported for the same school year may differ slightly from those in the earlier report. These differences reflect changes in the composition of responding centers rather than substantive inconsistencies in the measures. Sample sizes also vary slightly across outcomes due to differences in missing data. To keep the analysis comparable and easy to interpret, we restrict the main analysis to ER centers that enrolled in 2023. The main conclusions are unchanged when centers that enrolled in 2024 or later are also included.

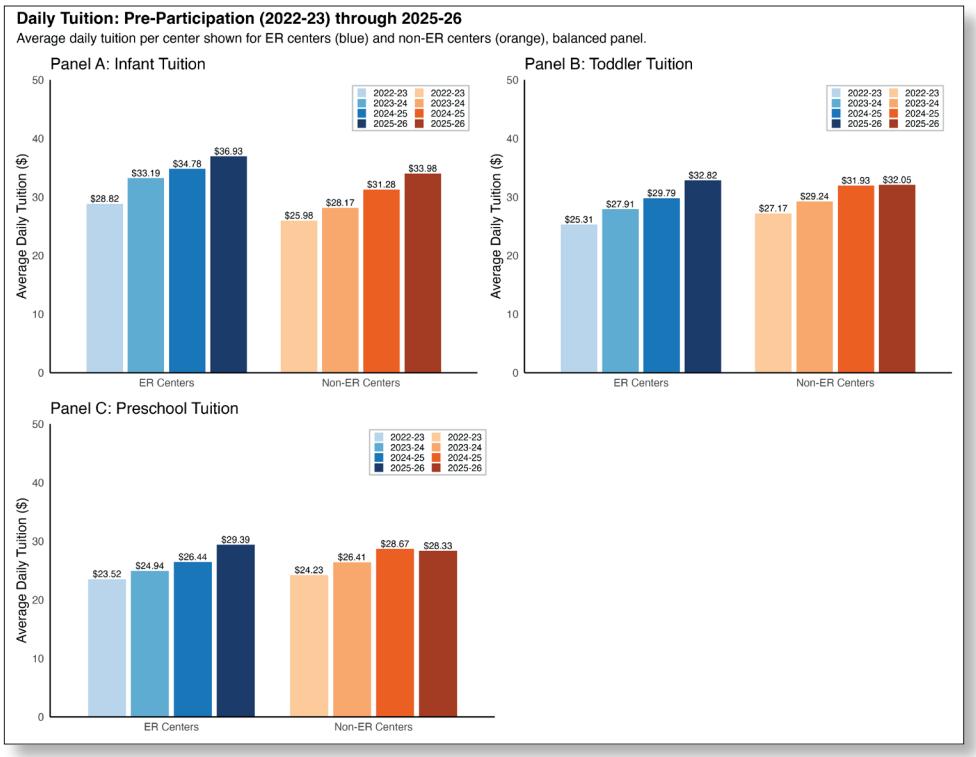
Figure 5.2



5.4 Tuition Trends

Figure 5.3 shows that the tuition centers charged to private paying families continued to rise into 2025–26. For infant care, average daily tuition increased to $36.93 in ER centers and $33.98 in non-ER centers. For toddler care, tuition rose to $32.82 in ER centers and $32.05 in non-ER centers. For preschool care, tuition reached $29.39 in ER centers and $28.33 in non-ER centers. Overall, the 2025–26 results remain broadly consistent with AR1: tuition increased over time, but ER and non-ER centers continued to report similar tuition levels with the exception of the statistically significant infant-care difference in 2023-24.

Figure 5.3



Key Insights of This Report

1. Early REACH had positive effects on primary caregiver employment, including an overall 57% increase in transition to employment over non-Early REACH primary caregivers and an 11% increase in the job-retention rate.
2. The transition into employment for those in the program was 18.6 percentage points higher in the first year (relative to non-participants), and 27.7 percentage points higher for those in the program 12-24 months, indicating a positive effect of time-in-program.
3. Though there is an Early REACH center within 2.65 miles on average from PCs' homes, Early REACH families travel an average of 6.73 miles to their enrolled Early REACH provider. This likely reflects a combination of caregiver preferences, the fact that in some parts of Harris County centers were far spread, and the limited availability of ER slots.
4. While much of the ER-funded capacity substituted for pre-existing slots rather than opening new ones, enrollment grew 25% above the 2022–23 baseline among the ER center subsample, compared with 2.7% growth among non-ER centers over the same period.
5. Over its time in operation, the Early REACH program has reduced average center vacancy rates and cost paid per student, and increased the total number of slots filled/children enrolled.
6. Staffing levels and staff wages continued higher at ER centers than at non-ER centers and tuition levels at both rose at similar rates.

To Come in Future Reports

In subsequent reports, we will dive more deeply into the issues explored herein and we will expand our analyses of ER effects for Families and Centers, including but not limited to the topics that follow:

- survey families whose children have aged out of the Early REACH program, focusing on where children go, changes in caregivers' employment, and household financial well-being after program exit
- continue to study the effect of ER on earnings and type of employment
- explore center functioning and sustainability under a contracted slot payment system
- report on how ER centers allocate program funds and how their spending patterns change over time
- discuss the wider effect of the program on the economy and the community, to the extent measurable
- describe returns on investment

The final report will summarize and analyze the cumulative findings.

Preliminary observations:

In this unusual circumstance where the program is ending before the evaluation is completed, preliminary observations have been requested of us, for policy makers to keep in mind thinking forward.

We offer the following while noting that the evaluation is not complete, and the recommendations in the final report may differ, based on fuller information.

- Demand for the Early REACH program is large. Given the large underlying demand for affordable high-quality child care, 820 slots are a drop in the bucket. But they are a start, and if more slots could be offered and more centers involved, families, centers, and employers would benefit.
- When offered ER slots, caregivers' employment rates increase, substantially, even in the absence of any employment requirement.
- Continuity increases returns on investment. Caregivers' employment increased over time in the program, while costs per child served reduced over time for the program as centers filled open spots.

Acknowledgments

Thanks to Brian Murphy and Vi Huynh, for their assistance in the research process, as well as to the Center Directors and Primary Caregivers who shared their knowledge and experience in the surveys and interviews.

APPENDIX

Summary Statistics - Demographics

	Full Sample mean/sd/count	ER Families mean/sd/count	Non-ER Families mean/sd/count	Diff b
Primary Caregiver: Mother	0.93 (0.26)	0.94 (0.25)	0.93 (0.26)	0.01
Married	0.17 (0.38)	0.19 (0.39)	0.16 (0.37)	0.03
Non-Hispanic White	0.07 (0.25)	0.05 (0.23)	0.07 (0.26)	-0.02
Non-Hispanic Black	0.62 (0.48)	0.62 (0.49)	0.63 (0.48)	-0.01
Hispanic	0.26 (0.44)	0.29 (0.46)	0.24 (0.43)	0.05
Asian/Pacific Islander/Other	0.05 (0.21)	0.03 (0.18)	0.05 (0.23)	-0.02
Some high school or less	0.06 (0.23)	0.05 (0.22)	0.06 (0.24)	-0.01
High school grad or equivalent	0.28 (0.45)	0.29 (0.46)	0.28 (0.45)	0.02
Some College/Associates Degree	0.47 (0.50)	0.46 (0.50)	0.47 (0.50)	-0.01
Bachelor's or Higher	0.17 (0.38)	0.16 (0.37)	0.17 (0.38)	-0.01
Household size at application	3.18 (1.31)	3.33 (1.38)	3.07 (1.25)	0.26**
N of children at application	1.51 (0.80)	1.72 (0.92)	1.36 (0.67)	0.36***
Eligible for Earned Income Tax Credit	0.43 (0.50)	0.42 (0.49)	0.44 (0.50)	-0.02
Eligible for Child Tax Credit	0.46 (0.50)	0.48 (0.50)	0.45 (0.50)	0.03
Receives Medicaid Benefits	0.60 (0.49)	0.60 (0.49)	0.60 (0.49)	-0.00
Receives Food Stamps	0.47 (0.50)	0.42 (0.49)	0.50 (0.50)	-0.08*
Receives Women, Infants, and Children Benefits	0.46 (0.50)	0.43 (0.50)	0.48 (0.50)	-0.05
Receives Unemployment Benefits	0.02 (0.12)	0.01 (0.12)	0.02 (0.13)	-0.00
Has child in daycare 22-23	0.37 (0.48)	0.29 (0.45)	0.43 (0.50)	-0.14***
Applied in 2023	0.42 (0.49)	0.59 (0.49)	0.31 (0.46)	0.28***
Applied in 2024	0.32 (0.47)	0.31 (0.46)	0.33 (0.47)	-0.02
Applied in 2025	0.25 (0.43)	0.10 (0.30)	0.36 (0.48)	-0.26***
N	**744**	**297**	**447**	

*Standard errors in parentheses; * p<.10, ** p<.05, *** p<.01.*