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HB26-1327 MAY HARM COLORADO'S ECONOMY WITHOUT ENHANCING EMPLOYER-BASED HEALTH INSURANCE COVERAGE

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INTRODUCTION

During the 2026 legislative session, Colorado's lawmakers may consider HB26-1327, which would establish a Large Employer Health-Care Support Enterprise and impose a $2,300 annual fee on large employers per Medicaid-enrolled worker.

According to CSI's analysis, large employers are relatively generous when it comes to providing health care coverage for employees. For example:

- Large private employers, those with 500 or more workers, cover 81% of single premiums and 75% of family premiums.
- Meanwhile, employers with 1 to 49 workers pay 79% of single premiums and 64% of family premiums.
- State and local government employers typically cover 80% of the single premium and 69% of the family premium.

This legislation would make it more difficult for large employers to create jobs (especially part-time work) and to keep existing employees on the payroll. If enacted into law, the bill also will erode business sales. The legislation could also:

- Decrease employer-sponsored insurance
- Reduce wages for certain employees
- Create labor market distortions, mostly in low-wage sectors
- Lead to higher prices for consumers of products offered by large employers. Health insurance costs are rising, but penalizing large employers will not enhance coverage and may actually result in fewer state residents finding work.

KEY FINDINGS

- On balance, HB26-1327 would **reduce the number of jobs in Colorado by 1,041 by 2035.**
- Healthcare providers and supply chains would gain 563 jobs by 2035. However:
- Higher costs on households and reduced demand for low-wage labor, leading to employment declines totaling 1,604 jobs by 2035.
- HB26-1327 will reduce business sales.
- Higher revenue to health care providers and their suppliers will generate a positive direct and indirect impact on business sales totaling **$917 million by 2035.**

However:

- Increased labor costs, higher prices, and marginally reduced employment for low wage workers will reduce business sales by **$1.5 billion.**
- Only employers in the health care sector will benefit from HB26-1327:
- Occupations with an **overall increase** in job counts by 2035:
- Health diagnosing and treating practitioners, other healthcare support occupations.
- Occupations with an **overall decrease** in job counts by 2035:
- Retail sales workers, material moving workers, construction workers, food and beverage serving workers, motor vehicle operators, other installation, maintenance, and repair occupations, cooks and food preparation workers, business operations specialists
- HB 26-1327 increases the f**ees on employers** annually by **at least $106 million** in fiscal year (FY) 2031.
- HB26-1327 estimates approximately **46,000 Medicaid-enrolled workers** employed at large firms will be subject to the new fee, roughly 16% of potentially affected workers.

WHAT IS HB26-1327?

HB26-1327 will raise fees on Colorado employers.

The proposed legislation establishes a Large Employer Health-Care Support Enterprise and imposes a $2,300 annual fee on large employers per Medicaid-enrolled worker.[i] Per the published fiscal note, the policy is expected to generate approximately $107 million annually beginning in fiscal year (FY) 2031 and primarily shifts Medicaid costs from the state General Fund to employers. The bill is anticipated to generate approximately $33.3 million annually from FYs 2028 through 2030.[ii] Based upon the published fiscal note, the bill may not require the type of voter approval required by Proposition 117 of 2020.[iii]

HB26-1327 is a response to Colorado's incredibly tight budget. (For reference, CSI has previously highlighted enormous growth in *Medicaid and Department of Health Care Policy and Financing* compared to the rest of the state budget.[iv]) Given this pressure, one way to balance the state budget is to shift some of the notional costs of Medicaid onto large employers—thus, HB 26-1327.

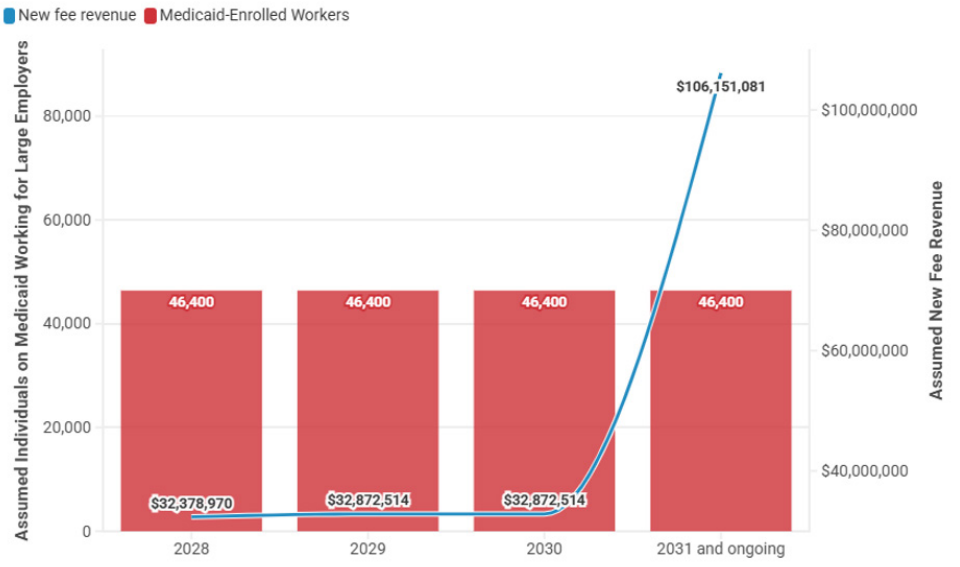
This bill has the potential to: *increase* or *decrease* employer-sponsored insurance, reduce wages for certain employees, create labor market distortions, mostly in low-wage sectors, and lead to higher prices for consumers of products offered by large employers.

The bill applies to employers with 500 or more Medicaid-enrolled workers who are over the age of 18 and are not seasonally employed.

FIGURE 1.

Fiscal Note Assumptions for HB 26-1327 Large Employer Worker Healthcare Support

The fiscal note appears to assume that the fee will be set to avoid voter approval requirements as set forth by Proposition 117 of 2020.



Source: Colorado General Assembly, HB26-1327 fiscal note, Colorado General Assembly, Proposition 117 Detail

The bill exempts employers that[v]:

- provide health coverage to all workers working 20 hours or more per week or 80 or more hours per month;
- are franchisees;
- are registered nonprofits;
- are public employers; or
- have collective bargaining agreements with their employers.

Revenues would be used to support Medicaid funding and increase provider reimbursement rates.

Not considering the dynamic economic impact, the bill could generate at least $106 million annually beginning in FY 2031. Administrative costs, as reported on the fiscal note, include $95,000 for initial setup costs and approximately $700,000 in ongoing costs for five full-time equivalent employees (FTEs).[vi]

Notably, the employer fee-based system for Medicaid-enrolled employees shifts funding from the General Fund to enterprise revenue. The structure allows funds to be treated as exempt from TABOR constraints.

LARGE EMPLOYERS PAY A LARGE SHARE OF EMPLOYEE HEALTHCARE COSTS

Overall, employer-sponsored insurance remains the dominant source of health coverage for working-age Americans, but access and employer cost-sharing vary substantially by employer size and sector. Large employers are much more likely than small employers to offer coverage, while state and local government workers are more likely than private-sector workers to have access to and participate in employer health plans.

Costs also are rising. Nationally, average annual premiums reached $9,325 for single coverage and $26,993 for family coverage in 2025, with workers contributing $1,440 and $6,850, respectively.[vii] In Colorado, the average annual premium for private-sector employer-sponsored insurance was $7,349 for single coverage and $21,768 for family coverage in the 2021–2023 pooled MEPS-IC estimates, with workers contributing $1,650 and $6,587, respectively.[viii]

In terms of numbers, nationally employer-sponsored coverage varies substantially by employer type and size. In March 2025, 72% of private-industry workers had access to an employer medical plan, compared with 89% of state and local government workers. Within private industry, access and participation rise sharply with employer size: workers at establishments with 500 or more employees had a 90% access rate and 76% participation rate versus 54% and 31%, respectively, at establishments with 1 to 49 workers.

Large private employers also pay a larger share of premiums than smaller firms, covering 81% of single premiums and 75% of family premiums at establishments with 500 or more workers, compared with 79% and 64% at establishments with 1 to 49 workers.[1,ix]

[1] It is worth noting that the U.S. Bureau of Labor Statistics size categories are establishment size (e.g., 500+ workers at an establishment), while HB26-1327 is aimed at large employers. Because of this, the table is best used as a comparison guide than a direct estimate of affected firms.

FIGURE 2.

Employer category	Access to medical plan (%)	Participation (%)	Take-up (%)	Employer share of single premium (%)	Employer share of family premium (%)
Private industry, all workers	72	45	63	80	69
State & local government, all workers	89	67	75	87	72
Private industry, 1–49 workers	54	31	58	79	64
Private industry, 50–99 workers	73	43	58	79	63
Private industry, 100–499 workers	86	60	70	80	69
Private industry, 500+ workers	90	76	84	81	75

IT IS UNCLEAR HOW MANY INDIVIDUALS THE BILL WOULD IMPACT

Because we do not know how employers and employees will evaluate the costs and benefits of the new fee, it is difficult to estimate how many Colorado employees the legislation would affect.

We have estimated the potential universe, however.

Table 2A is from HB 26-1327's fiscal note (Figure 2), but we have added one line: the potential universe of eligible employees in orange.[x] Notably, the total universe of 294,582[2] employees (which excludes 39,352 employees who work less than 20 hours per week) is much larger than the 46,400 universe presented in the fiscal note.

As noted in the fiscal note, only a share of the potential universe will be affected. Figure 2 does not break down how many of the individuals work for non-exempt large employers for more than 20 hours per week.

FIGURE 3.

Potential Universe of Affected Employees

The current fiscal note for HB 26-1327 assumes approximately 46,000 affected employees, the potential universe of affected employees is about 295,000.

Employment Status	Estimated Percentage	Estimated Enrollment
Working full-time (40+ hours per week)	15%	127,805
Working part-time (20 to 39 hours per week)	17%	140,582
Working part-time (less than 20 hours per week)	5%	39,352
Working but hours unknown	3%	26,195
Potential Universe		294,582
Unemployed but looking for work	17%	144,404
Not in labor force	22%	188,270
Not working due to disability	21%	177,094
Total Working Full- or Part-Time	40%	333,934

Source: Colorado General Assembly

[2] The bill's current fiscal note appears to start with a potential universe of 333,934, which includes 39,352 individuals working part-time for less than 20 hours per week.

THE BILL MAY INCREASE OR DECREASE EMPLOYER-PROVIDED HEALTHCARE COVERAGE

It is uncertain whether businesses will increase or decrease employer-provided healthcare coverage in response to the proposed new fee. What follows is a discussion on factors that will weigh on employers' healthcare coverage decisions.

Mechanisms Increasing Employer-Provided Coverage

Employers may respond to the fee by expanding or improving health benefits to avoid paying the fee. Their options include lowering employee premium contributions, expanding eligibility to more workers, reducing waiting periods, and improving affordability of family coverage. Large companies who are currently close to offering what is deemed affordable coverage may shift toward providing enhanced health insurance.[xi,xii]

Mechanisms Decreasing Employer-Provided Coverage

In low-margin industries, employers may respond by reducing hiring, cutting hours, or shifting workers below eligibility thresholds for benefits. These options may reduce the number of workers eligible for employer-sponsored insurance.[xiii,xiv]

Employers may also shift compensation structures, increase employee premium contributions, or reduce plan generosity, which could erode the effectiveness of coverage even if coverage is technically offered.[xv]

Some firms may restructure operations—such as franchising, outsourcing, or reorganizing workforce arrangements—to reduce exposure to the fee, potentially lowering direct provision of healthcare benefits.

WHY ARE SOME EMPLOYEES OF LARGE FIRMS WORKING MORE THAN 20 HOURS PER WEEK ON MEDICAID?

Given that large firms generally offer healthcare to their employees, why are some employees at these firms on Medicaid?

- Although employed, wages are low enough to qualify for Medicaid.
  - For expansion adults, Medicaid eligibility is approximately 138% of the federal poverty level.
  - Industries that generally employ a larger share of low wage workers (and generally low margins) include:
    - Retail
    - Hospitality
    - Food service
    - Logistics
    - Warehousing
    - Healthcare support
- Some workers may work less than 30 hours per week, which is the Affordable Care Act (ACA) threshold for employer coverage, and as such, may not be eligible for health insurance benefits from their employer.
- Health insurance coverage is expensive. For example:
  - Premiums are too high relative to wages.
  - Deductibles are large.
- Family coverage is especially expensive, and ACA affordability only applies to single coverage, creating a "family glitch." Workers in this situation with children may opt for Medicaid.

- Children qualify for Medicaid at higher income levels, meaning a worker may have their employer-sponsored insurance for themselves, but to reduce their costs, they use Medicaid coverage for their children.
- Employees may be on Medicaid for other reasons, such as:
  - Missing their employer's enrollment period.
  - Waiting periods for employer coverage.
  - Medicaid redetermination timing.
- Some workers may qualify for Medicaid if they have disabilities, high medical needs, or qualify under medically needy pathways.

HOW THE BILL WILL AFFECT HEALTHCARE PROVIDERS AND LOW WAGE WORKERS

With this background, what is the likely economic impact on workers and employers from implementation? The answer to this question largely depends on how firms and employees respond.

To model the impact, CSI employed REMI Tax PI+ to estimate the impact on businesses, consumers, and health care providers by using REMI's production cost and consumer tax (increase labor costs and prices) and a corresponding increase in revenue to healthcare providers. Appendix A contains details regarding this modeling. Below are the modeling results of how businesses, employees, and consumers could be affected in response to the proposed change.

Presented first is the direct, indirect, and induced economic impact for output (i.e., business sales) and employment followed by the broader overall impact as measured by gross domestic product (GDP), personal income, and other economic measures.

Direct, Indirect, and Induced Impact

If enacted into law, HB26-1327 would result in a net drop in jobs in the state. The health care industry is the only sector where employment would not decline.

The bill could drive positive direct and indirect employment effects due to increased revenue flowing to health care providers and their supply chains. REMI estimates that direct employment rises by 206 jobs in 2027, increasing to 562 jobs by 2030, before moderating slightly to 480 jobs by 2035. Similarly, indirect (supplier) employment increases by 34 jobs in 2027, 95 jobs in 2030, and 83 jobs in 2035, reflecting expanded demand for goods and services supporting the health care sector.

These gains are offset by negative induced employment effects, however, which capture broader impacts on households through higher costs and reduced demand for low-wage labor. Induced employment declines by 616 jobs in 2027, worsening to 1,826 jobs in 2030, and remaining elevated at 1,604 jobs lost in 2035.

On balance, total employment is projected to decline by 376 jobs in 2027, 1,170 jobs in 2030, and 1,041 jobs in 2035.

These results indicate that the negative household and labor market adjustments of HB26-1327 outweigh the positive effects in the health care sector.

FIGURE 4.

Category	Units	2027	2030	2035
Total Employment	Individuals (Jobs)	-376	-1,170	-1,041
Direct Employment	Individuals (Jobs)	206	562	480
Indirect Employment	Individuals (Jobs)	34	95	83
Induced Employment	Individuals (Jobs)	-616	-1,826	-1,604

Net business sales in the state also would decline. Due to the positive revenue effect on health care providers and their suppliers, the policy generates cumulative direct and indirect output (business sales) from 2027 through 2035 of $917 million, but that improvement is offset by an induced decrease of $2.4 billion stemming from the higher costs for lower wage workers and prices for consumers.

FIGURE 5.

Category	2027	2030	2035	Cumulative Impact
Total Output	-$33,868,492	-$154,648,593	-$185,961,069	-$1,468,634,472
Direct Output	$35,333,467	$106,000,813	$106,000,626	$742,003,190
Indirect Output	$8,182,175	$24,875,749	$25,101,107	$174,806,485
Induced Output	-$77,384,134	-$285,525,155	-$317,062,801	-$2,385,444,147

Overall Economic Impact

Individual workers also would be worse off under HB26-1327.

Figure 6 presents the impact on employment, GDP, output (business sales), personal income, disposable personal income, real personal income (inflation-adjusted personal income), and inflation. The far right column has the cumulative impact for the financial variables or the average annual impact for employment.

Overall, employment is, on average, lower by 862 jobs each year than it would be without the legislation. The cumulative decline in personal income is $283 million, the cumulative decline in disposable personal income is $248 million, and the cumulative decline in inflation-adjusted disposable personal income is $575 million. Pressure to raise prices to cover the increased costs for labor would raise the cost of living for everyone across the state by an estimated 0.027% in 2035.

FIGURE 6.

Category	2027	2030	2035	Cumulative impact (all except employment) / avg. annual for employment
Total Employment	-376	-1,170	-1,041	-862
Gross Domestic Product	-$22,606,248	-$99,463,494	-$120,297,493	-$242,367,236
Output	-$33,868,492	-$154,648,593	-$185,961,069	-$374,478,154
Personal Income	-$27,769,966	-$110,187,438	-$145,376,559	-$283,333,964
Disposable Personal Income	-$23,887,307	-$95,767,145	-$128,626,836	-$248,281,287
Real Disposable Personal Income	-$81,151,495	-$248,233,373	-$245,767,607	-$575,152,475
PCE-Price Index (Inflation, %)	0.013%	0.034%	0.027%	

Occupational Impact

Workers in low-wage industries would be harmed the most.

The impact is perhaps most clear when viewed through the occupational lens. Appendix B shows the employment impact for 2027, 2030, and 2035 sorted in the order of the largest declines in employment in 2035. The occupations with estimated increases of 19 or more in 2035 are shown at the bottom of the table.

Overall, as one might expect given the heavy concentration of lower wage workers within the sector, retail sales workers see the largest declines in employment. Jobs in that sector are reduced by 111 in 2035. Other job titles with disproportionate drops in employment include material moving workers, construction workers, food and beverage serving workers, motor vehicle operators (couriers), other installation/maintenance/repair occupation workers, cooks, and business operations specialists.

On the other end of the spectrum, new revenue flowing to health care providers shows up in increased employment for health diagnosing and health practitioners and other health care support occupations.

BOTTOM LINE

Overall, the proposed fee on large employers for employees on Medicaid has profound economic effects and many of them are not positive. While the health care sector may enjoy marginal benefits from the new revenues that would flow to it, business output, along with overall economic growth, would suffer. Consumers would face higher prices and there would likely be declines in overall employment, especially in low wage sectors. Even more problematic is that these consequences may emerge without an assured increase in employer-sponsored coverage for workers.

APPENDIX A: MODELING ASSUMPTIONS

The Regional Economic Models, Inc. (REMI) Tax-PI+ model is a dynamic, multi-regional economic forecasting and policy simulation tool that integrates input-output, computable general equilibrium (CGE), econometric, and economic geography frameworks. It is used to estimate the economic impacts of policy changes across industries, households, and government sectors over time.

The REMI model structure allows for input-output relationships to capture inter-industry supply chains, while the CGE features allow prices, wages, and substitution effects to adjust in response to shocks. Additionally, the econometric components estimate behavioral responses using historical data and the spatial dynamics capture migration, commuting, and regional competitiveness.

Application to HB26-1327

HB26-1327 is modeled as a targeted increase in labor costs for large employers whose workers are enrolled in Medicaid. The primary shock is introduced as an increase in employer production costs (labor costs) in affected industries, including retail, accommodation and food services, administrative support, and logistics.

DESIGN

The model incorporates a phased implementation: one-third of the policy impact in 2027, 2028, and 2029, with full implementation beginning in 2030. The total annual impact is set at $106 million. The shock is allocated across industries based on estimated Medicaid participation using Current Population Survey (CPS) data.

INDUSTRY SHARE OF IMPACT

Certain businesses are disproportionately impacted. The model allocates the total impact according to the following shares: retail trade (35%), accommodation and food services (30%), administrative and support and waste management (15%), transportation and warehousing (10%), and other services (10%). The detailed sector impacts underneath these four broad sectors are estimated using the share of employment within the broad sectors. Other sectors that could be added with further evidence include

health care and social assistance and construction. On the spending side, the model assumes 65% would be allocated to hospitals and 35% to ambulatory care. This spending side impact is modeled through an increase in industry sales, exogenous production in REMI.

HIGHER CONSUMER PRICES

In addition to the employer cost side and increased revenue to healthcare providers, the model assumes that half of the increased employer costs will be made up through higher consumer prices through the consumer tax variable for the detailed industries.

FISCAL RECYCLING

Revenue collected from employers is modeled as an increase in state government revenue, which is then recycled into the economy through increased health care spending. This revenue is implemented as increased demand in hospital and ambulatory healthcare sectors, reflecting Medicaid reimbursement flows.

BEHAVIORAL RESPONSES

REMI endogenously captures employer and worker responses, including changes in wages, employment, prices, and migration. Higher labor costs generally reduce employment in affected sectors, while increased health care spending generates offsetting economic activity in the health care sector. The model uses an immediate market share response.

OUTPUTS

Among the sector and economic outputs, key outputs include changes in employment, GDP, personal income, industry output, and population. The model also captures indirect and induced effects through supply chains and household spending.

APPENDIX B: OCCUPATIONAL IMPACT

Occupation	2027	2030	2035
All Occupations	-376	-1,170	-1,041
Retail sales workers	-47	-131	-111
Material moving workers	-36	-104	-92
Construction trades workers	-47	-148	-91
Food and beverage serving workers	-27	-78	-76
Motor vehicle operators	-26	-78	-70
Other installation, maintenance, and repair occupations	-16	-51	-43
Cooks and food preparation workers	-15	-43	-42
Business operations specialists	-15	-48	-42
Top executives	-14	-43	-37
Nursing, psychiatric, and home health aides	-9	-28	-29
Building cleaning and pest control workers	-10	-30	-28
Other management occupations	-8	-28	-25
Financial specialists	-9	-27	-25
Information and record clerks	-9	-27	-25
Computer occupations	-6	-21	-22
Vehicle and mobile equipment mechanics, installers, and repairers	-8	-22	-20
Other office and administrative support workers	-7	-23	-19
Supervisors of sales workers	-8	-21	-18
Sales representatives, services	-7	-20	-17
Supervisors of food preparation and serving workers	-6	-17	-16
Other food preparation and serving related workers	-6	-17	-16
Other sales and related workers	-5	-16	-15
Other personal care and service workers	-6	-16	-14
Operations specialties managers	-4	-14	-14
Financial clerks	-5	-17	-14
Supervisors of construction and extraction workers	-7	-22	-14
Personal appearance workers	-6	-16	-13
Material recording, scheduling, dispatching, and distributing workers	-5	-15	-13
Other protective service workers	-4	-11	-10
Other production occupations	-4	-11	-10
Sales representatives, wholesale and manufacturing	-4	-11	-10
Other occupations	9	-15	-48
Other healthcare support occupations	9	24	19
Health diagnosing and treating practitioners	19	49	38

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