Private health insurance basics

The primary purpose of health insurance is to protect people against the uncertainty and high cost of healthcare expenses.[1] A single severe health incident can lead to medical bills that cost tens of thousands of dollars. Health insurance is intended to make these costs more predictable by requiring a regular premium payment and limiting out-of-pocket expenses.

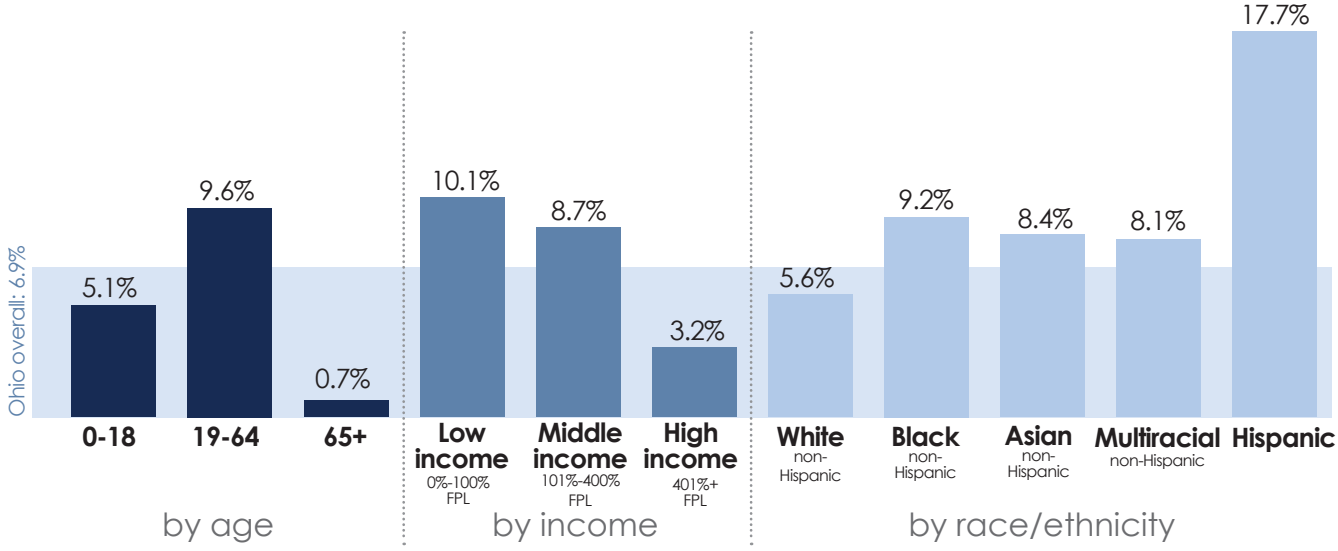
Insurance plans can come from both private sources, like employers, and public sources, like federal health insurance programs. Specific details, including how much a consumer must pay for care, what services are covered and what regulatory requirements a health insurance issuer must follow, differ across plan types.[2]

3 Key findings for policymakers

1. **Health insurance protects against negative health and financial outcomes**, including premature death, medical debt and more.
2. **Employer-sponsored insurance is the most common form of health coverage in Ohio.** Individual plans differ in terms of costs and benefits.
3. **The cost of private health insurance has increased significantly for Ohioans** in recent years, including for employer-sponsored coverage and ACA marketplace plans.

Figure 1. **Ohio's uninsured population, 2024**

In 2024, 93.1% of Ohioans had health insurance coverage, which ranks Ohio 22nd among all states and D.C. The other 6.9% (about 820,000 Ohioans) were uninsured. Some groups are more likely to be uninsured than others, including people with lower incomes, working-age Ohioans (ages 19-64) and Hispanic and Black Ohioans.



Source: HPIO analysis of U.S. Census Bureau, American Community Survey Public Use Microdata, 1-year estimates

About Health Insurance Basics

This brief provides a summary of private health insurance in Ohio. Additional resources can be found at the end of this summary and on **HPIO's website**.

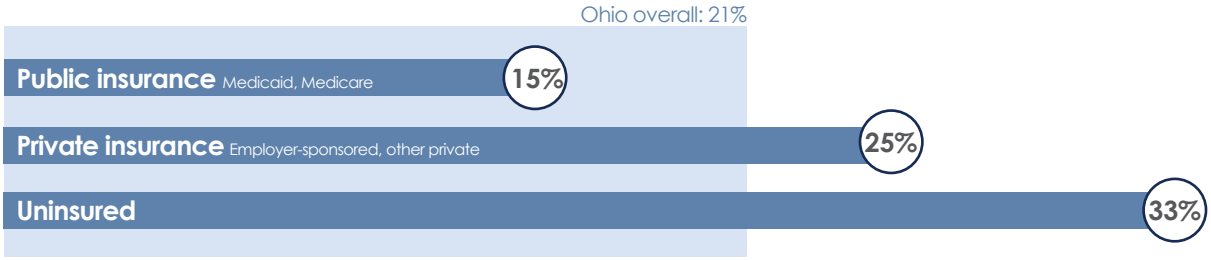
Having health insurance is associated with important positive health and financial outcomes. People who are uninsured are more likely to:

- Die prematurely[3]
- Delay or forgo care, including preventive services and screenings[4]
- Have medical debt or declare medical bankruptcy[5]
- Experience financial distress and difficulties meeting basic needs[6]

Because of variation in health insurance costs and coverage, many people with health insurance still experience issues accessing affordable healthcare services. In 2024, the Commonwealth Fund estimated that 23% of adults were underinsured, meaning they had health coverage but still had to spend a large amount of their household income on healthcare expenses that insurance did not cover (also called **out-of-pocket expenses**).[7]

Figure 2. **Percent of Ohio adults who had trouble paying off medical bills in the last year, 2023**

While uninsured Ohioans are most likely to experience difficulties paying medical bills (33% in 2023), a substantial portion of people with health insurance struggle as well, including 1 in 4 people with private insurance.



Source: HPIO analysis of Ohio Medicaid Assessment Survey

Accessing healthcare without insurance

People who are uninsured often forgo care out of concern that they will face expensive medical bills.[8] Some individuals may receive services through what is called the **healthcare safety net**, which includes free clinics and federally qualified health centers.[9] However, patients may experience delays and limitations in these settings due to insufficient resources, especially for more specialized care.[10]

Many people without insurance end up in the hospital emergency room when a significant health event occurs, including for conditions that could have been treated in an outpatient setting if addressed earlier.[11] The **Emergency Medical Treatment and Labor Act** (or EMTALA) requires hospitals to provide emergency stabilization services regardless of a patient's ability to pay, however, the cost of treatment is still the responsibility of the patient.

Some people without insurance may be eligible for financial assistance offered through providers. All U.S. non-profit hospitals are required to have a **financial assistance policy** that provides free or discounted care to eligible low-income patients (with or without insurance), and other providers may have similar policies. However, patients frequently face **barriers to accessing this assistance**, including lack of knowledge about their availability.

Sources of health insurance in Ohio

There are five main sources of health insurance coverage, two of them private and three of them public.

Focus of this brief

Private health insurance:

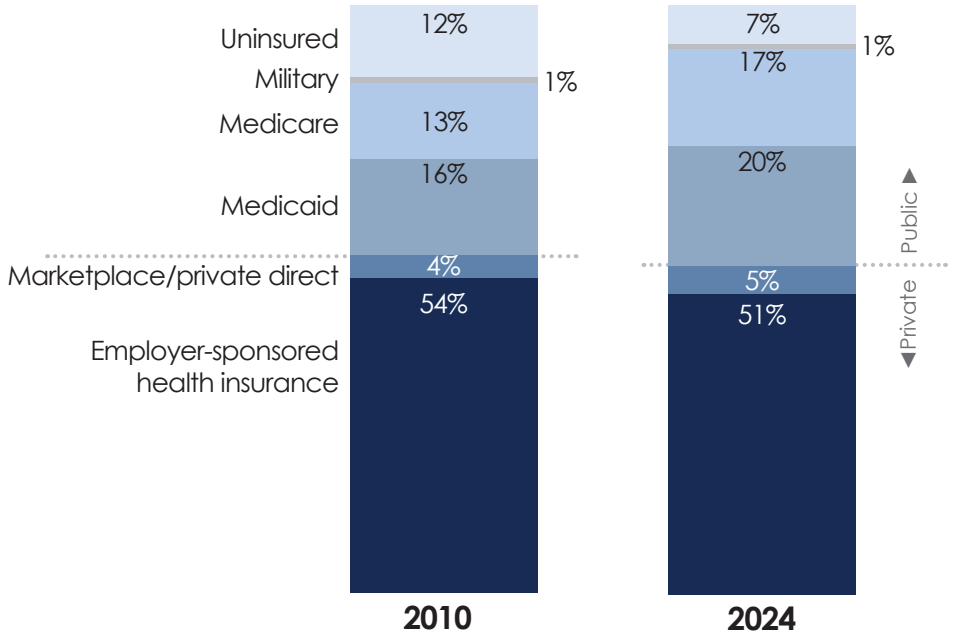
- **Employer-sponsored insurance.** Offered by many employers to workers and dependents as a benefit of employment
- **ACA marketplace/private direct purchase.** Purchased from a private insurance company, sometimes with subsidies

Public health insurance:

- **Medicaid.** Covers low-income Ohioans and people who have disabilities (for more information on Ohio's Medicaid program, see HPIO's **Medicaid Basics**)
- **Medicare.** Covers Ohioans who are 65 and older or those with a qualifying disability or medical condition (e.g., end-stage renal disease)
- **Military (Veterans Health Administration and TRICARE).** Serves some Ohioans who are veterans or active military, respectively, as well as some dependents

Employer-sponsored insurance is the most common form of coverage in Ohio, followed by Medicaid. Since 2010, coverage through public programs like Medicare and Medicaid has increased (figure 3). Ohio's overall uninsured rate has decreased by about half since 2010, in large part due to the expansion of Medicaid coverage starting in 2014 (see page 9).[12]

Figure 3. **Health insurance coverage by type in Ohio, 2010 and 2024**

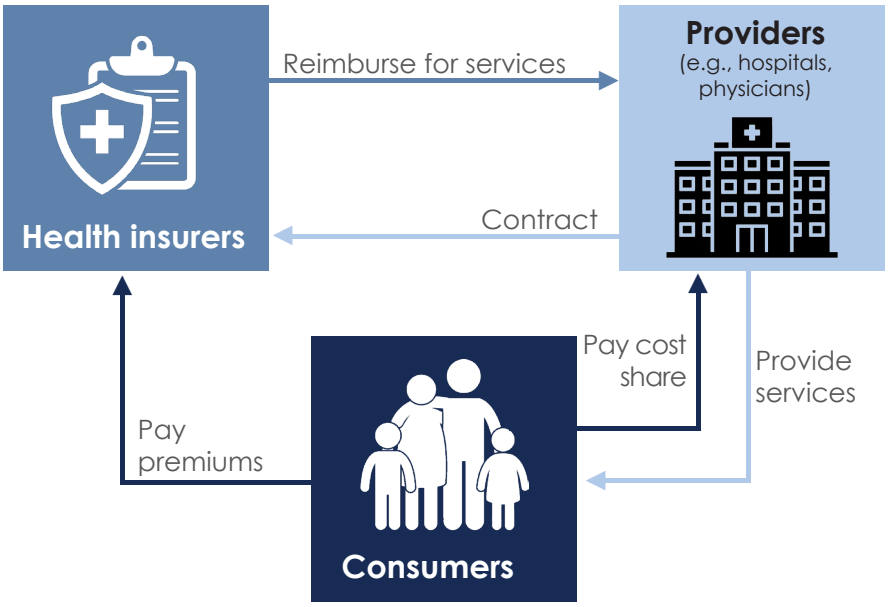


Note: Respondents may report having more than one type of coverage; however, individuals are sorted into only one category of insurance coverage. Individuals with Medicaid and another form of coverage (like Medicare or employer-sponsored insurance) were placed in the Medicaid category.
Source: U.S. Census Bureau, American Community Survey 1-year estimates, as compiled by KFF

How does health insurance work?

Despite variation across different types of health insurance, including whether it is public or private, the fundamental components of health insurance are similar. The following section provides an overview of the core functions of health insurance.

Figure 4. **Core functions of health insurance**



Note: This graphic provides a basic view of the relationship between insurers, providers and consumers. There are a number of real-world complexities not included in the graphic.

Enrollment and insurance pools

Individuals who enroll in an insurance plan are covered as part of a larger group called an **insurance pool**. To protect against the possibility of large sudden costs for a consumer in the event of a severe injury or illness, insurance works by spreading financial risk across a larger population that will include some people who require a high volume of health services and others who require less or even none.[13] By pooling the premiums of many people together, ideally with different levels of healthcare needs, the total cost of care becomes more predictable.

Issues can arise with insurance pools when the composition becomes disproportionately healthier or sicker. For example, if healthy individuals drop their coverage, the average claim costs and premiums will increase for those who remain insured.[14] If higher costs cause even more healthy people to drop coverage, leaving only those with the highest healthcare usage, the insurance pool will eventually collapse, which is referred to as an **insurance death spiral**.[15]

There are a variety of mechanisms used to mitigate this issue. For example, in order to prevent people from enrolling in or dropping coverage based on their anticipated healthcare needs (called **adverse selection**), individuals can usually only change plans during a designated annual enrollment period, or after a **qualifying life event**, such as job change, marriage or having a baby.[16] Insurers also use risk management tools to protect against high costs.[17] Public insurance programs can address situations where constructing stable insurance pools is difficult, including for populations with high overall levels of health needs like older individuals.[18]

Costs and payments

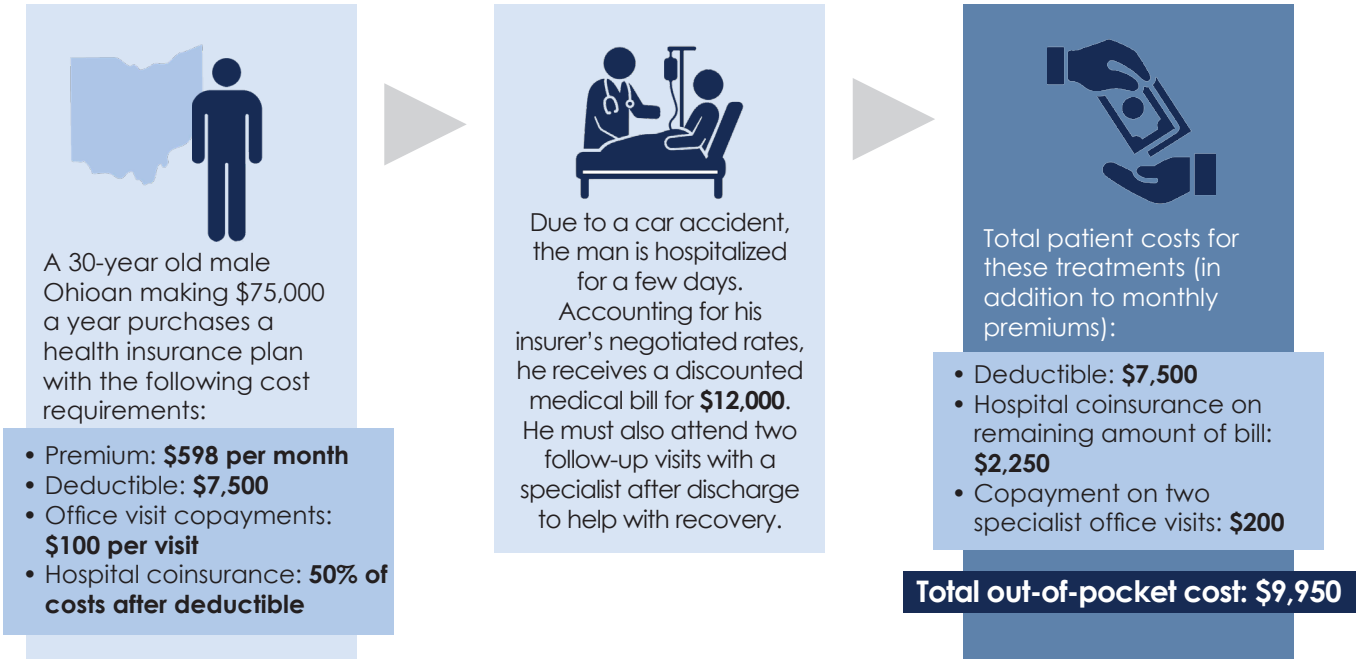
As part of obtaining and keeping health insurance, consumers (i.e., individuals covered by insurance) are usually responsible for regular **premiums** in addition to out-of-pocket expenses when receiving health services. The specific responsibilities of the consumer are detailed as part of the insurance plan. For more information on consumer costs in health insurance, see the **State Health Access Data Assistance Center Basics Page**.

Key terms

Premiums	A set amount paid in regular increments (usually monthly) to keep insurance, regardless of whether the covered individual or family receives health services. The entity responsible for premiums can vary; it may be solely the consumer's responsibility or partially/fully covered by an employer or subsidy.
Out-of-pocket expenses (cost sharing)	Expenses that a consumer pays for themselves when receiving health services can take different forms. Insurance plans usually have an **out-of-pocket maximum**, which is an amount (excluding premiums) after which the insurer will cover all care costs. The federal government sets out-of-pocket maximums for some types of plans.
▶ **Deductible**	A set amount that a consumer pays during a benefit period or plan year for covered services before the insurer begins to make payments toward those services. Certain types of care such as preventive services may be exempted from the deductible and therefore immediately paid in full by the insurer.
▶ **Co-payment**	A flat rate dollar amount paid by a consumer directly to the provider at the time of receiving a covered healthcare service. Co-payments do not generally count towards meeting the deductible.
▶ **Co-insurance**	A method of cost sharing in which the consumer is required to pay a defined percentage of their medical costs, usually after their deductible has been met.

An example of insurance payments for someone with private coverage is shown in figure 5.

Figure 5. **Example of health insurance in Ohio**



Notes:

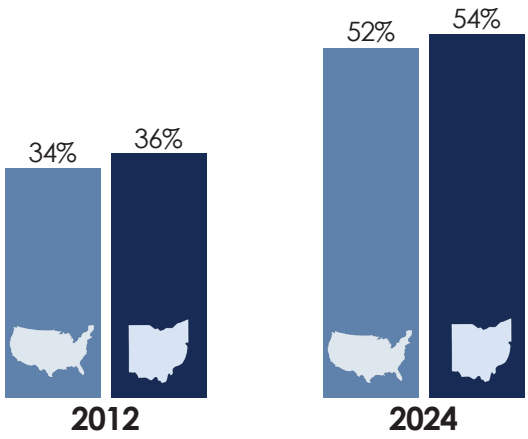
- For subsequent healthcare encounters during this plan year, the individual's deductible would be satisfied, meaning he would only be responsible for remaining copayments and coinsurance until hitting the plan's annual out-of-pocket maximum of $10,000
- These premium and cost-sharing estimates reflect a real health insurance plan available in Ohio on the ACA marketplace (see p. 12 for more information). The specific plan used in this vignette is the Caresource Bronze 7500 marketplace plan

After a consumer pays out-of-pocket expenses, the rest of the medical bill is paid for by the insurance plan to the provider (i.e., a hospital or physician) using a negotiated or assigned rate. **Reimbursement rates** for providers vary across plans but are generally highest for employer-sponsored coverage and lowest for Medicaid.[19]

High-deductible health plans

Across the various types of private insurance, **high-deductible health plans** (HDHPs) have become a common form of coverage.[20] HDHPs have a higher deductible compared to a traditional health plan but can typically be purchased for a lower monthly premium. The minimum deductible for a plan to be considered an HDHP in 2026 is $1,700 for individual coverage or $3,400 for family coverage, as designated by the **Internal Revenue Service**. More than half of private sector employees in Ohio have HDHPs, an increase of 49% since 2012. While HDHPs may reduce overall health care spending, they can also increase financial strain for consumers and lead individuals to delay or forgo needed care.[21]

Figure 6. **Percent of people with an HDHP, U.S. and Ohio, 2012 and 2024**



Source: Medical Expenditure Panel Survey - Insurance Component (MEPS-IC), Agency for Healthcare Research and Quality (AHRQ), Center for Financing, Access and Cost Trends (CFACT), as analyzed by SHADAC

HDHPs can be paired with special types of medical expense accounts that are tax-advantaged and used to cover out-of-pocket expenses. The most common is the **Health Savings Account** (HSA). An HSA can be funded with pre-tax dollars by a consumer or employer (up to $8,750 per year in 2026 for family coverage) and invested. When used towards qualifying medical expenses (excluding premiums), funds can also be withdrawn tax-free.[22]

HSAs help consumers with HDHPs cover their out-of-pocket expenses when receiving care, including those not covered by insurance.[23] Many eligible Americans do not open an HSA even if eligible, particularly if they do not have enough income or savings to make deposits.[24] **Flexible Savings Accounts (FSA)**, are similar, but contributions do not roll over each year and can be limited to specific service types (e.g., dental care).

Coverage and networks

Generally, insurance plans describe types of covered health services and which providers the consumer can see to receive these services. Covering more services or including more providers in the network generally increases premium costs.[25]

Covered benefits: The set of services, items and treatments that an insurance plan will cover.[26]

Some types of care, like inpatient hospitalization and physician office visits (when clinically appropriate), are almost always covered by an insurance plan. For other types of services, including infertility treatments, weight loss treatments, hearing aids, mental health services and more, coverage may depend on the specific plan. For example, about 9% of Ohio adults with a mental illness have insurance that does not cover treatment for mental or emotional problems.[27] Services like physical therapy can also have caps on the total number of uses or visits.[28]

While health insurance primarily covers physical and mental healthcare needs, coverage for dental, vision and prescription services is less consistent. They are frequently administered by a separate insurer or company and may be subject to different coverage limits.[29]

Provider network: Groups of healthcare providers contracted with an insurer to provide services under a health plan based on specified terms and negotiated reimbursement rates.[30]

Providers who are contracted under the health plan are considered **in-network**, while those who are not contracted are considered **out-of-network**. Services received in-network will generally be the most affordable for the consumer, while the use of out-of-network providers will be more expensive or possibly not covered at all by the plan.[31]

Covered benefits and provider networks are subject to differing regulatory requirements at both the state and federal levels (See Regulation section on page 9). For example, many insurance plans are required to offer coverage for a set of **essential health benefits**, such as prescription drugs, maternity care and mental health services. They must also have enough providers in-network within a geographic area to prevent access difficulties for consumers. This is known as **network adequacy**.[32]

Managed care

The traditional insurance model relied on **fee-for-service payments** and did not impose any restrictions on which provider the consumer chose. However, as healthcare spending rose in the mid-20th century, a new form of health insurance called **managed care** developed.[33]

Managed care organizations (MCOs) are private insurance companies that use specific techniques to contain overall costs. They can also help coordinate care for consumers and promote the use of preventive care. Almost all private insurance plans today are considered managed care.[34] Public forms of insurance also heavily rely on private MCOs, including Ohio's Medicaid program, where nine in 10 enrollees are covered by MCOs.[35]

Cost containment mechanisms

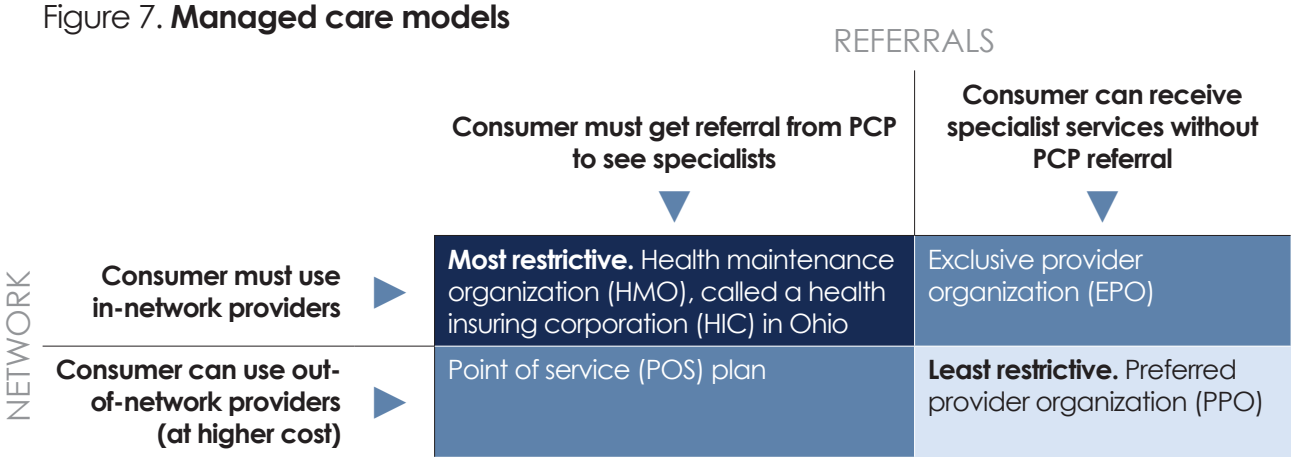
MCOs often use a variety of mechanisms to control costs, which are summarized below.

Utilization review	Techniques to monitor use of certain (usually more expensive) health services and ensure that treatment decisions are clinically appropriate.[36] *Example:* Requiring providers to receive approval for coverage of some treatments before a patient receives them (called **prior authorization**)
Selective contracting	Practice of working with a more limited network of providers to negotiate lower reimbursement rates for services.[37]
Gatekeeping	Requiring coordination of a patient's care through a primary care provider (PCP).[38] Not all MCOs use gatekeeping.

Managed care models

There are **different managed care models** that vary in their level of restriction (see figure 7). The least restrictive plans tend to have higher premiums, as the health plan will have less control over reimbursement rates and ensuring that specialty care is clinically necessary.

Figure 7. **Managed care models**



Note: The Ohio Department of Insurance does not recognize EPOs as a plan model. EPOs are not defined under Ohio law.[39]

Regulation of health insurance

Both the state and federal governments play a role in regulating health insurance, including public programs and private health plans. The lead regulatory agency is dependent on the type of insurance. The main regulators for Ohio insurance plans are:

- Ohio Department of Insurance (ODI), the state's insurance regulatory agency
- Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services
- U.S. Department of Labor
- Internal Revenue Service (IRS) within the U.S. Treasury Department

State-level regulation

States have generally held the primary responsibility for regulating private health insurance, though federal laws pre-empt state authority for some types of plans. Insurance companies that fail to comply with requirements can lose required licensing.

ODI regulates Ohio's health insurance market by:[40]

- Licensing insurers and insurance professionals
- Ensuring compliance with insurance laws and financial solvency standards
- Reviewing and approving insurance product filings and rates
- Protecting consumers and investigating fraud

Rates proposed by insurance companies must be filed with and reviewed by ODI, which evaluates whether the rates are supported by actuarial data and comply with applicable laws and regulations.

States have substantial flexibility in setting regulations for the plans they have jurisdiction over, requiring additional data reporting, mandating coverage of certain services or setting standards for network adequacy.[41] For example, the Ohio legislature has passed laws to mandate coverage of mammography, cervical cancer screenings and treatment for autism spectrum disorder.[42]

Federal-level regulation

While states hold a primary regulatory role, federal policies can pre-empt state-level requirements. For example, the **Health Insurance Portability and Accountability Act of 1996** (HIPAA) created a "federal fallback" for minimum regulatory standards, meaning that certain requirements will be enforced federally if the state chooses not to enforce them. Certain federal laws also limit the ability of states to regulate the insurance market, particularly for coverage through some employers (See page 11).

Changes to insurance regulation in the Affordable Care Act

In 2010, the federal Patient Protection and Affordable Care Act, often called the Affordable Care Act (ACA), made considerable changes to the regulation of health insurance. Some notable provisions include:[43]

- Requiring all citizens and legal residents to have health insurance (called the individual mandate) and large employers to offer health insurance for employees (called the employer mandate) or pay a tax penalty
- Expanding Medicaid coverage to adults with incomes below 138% FPL, creating a new Medicaid expansion eligibility category (sometimes also called Group VIII, MAGI Adult or Ribicoff coverage)
- Creating health insurance marketplaces for people to purchase individual/nongroup health coverage, with premium and cost-sharing subsidies for those meeting income eligibility criteria
- Prohibiting insurers from denying coverage or excluding benefits for a preexisting condition
- Prohibiting insurers from instituting annual or lifetime limits on what they will pay for an individual's care and limiting the annual amount an insurance enrollee spends out of pocket
- Creating a minimum standard of essential health benefits that must be covered under individual and small group plans
- Requiring insurance companies to spend a certain minimum percentage of premium revenue on medical care rather than administrative costs or profits, called the **medical loss ratio**

For more information about how the ACA changed the regulation of insurance, visit KFF's **Affordable Care Act 101**.

ACA provisions no longer in effect

Although most of the ACA remains in effect, several provisions were changed or discontinued. For example:

- In 2012, the Supreme Court ruled that states could choose whether to implement Medicaid expansion[44], which Ohio chose to do in 2014.
- The federal government stopped enforcing the individual health insurance mandate in 2017.[45]
- Several other ACA taxes were also discontinued (e.g., the medical device tax and the tax on very generous health plans).[46]

Types of private health insurance

Employer-sponsored insurance (ESI)	
Ohioans covered	**~5.9 million** (2024)
Coverage eligibility	Offered by many employers to individuals and dependents as a benefit of employment.
Costs for Ohioans	**Premium.** The average annual employee contribution in 2024 was $1,797 for an individual plan or $5,695 for a family plan. Employers cover 75-80% of the total premium, on average. **Cost sharing.** Varies substantially by plan. The average deductible in 2024 was $2,278 for individual coverage and $4,358 for family coverage.
Regulation	Self-insured plans (usually offered by larger employers) are regulated federally by the Employee Retirement Income Security Act (ERISA). Fully insured plans are subject to state-level regulations.

The most common source of health insurance in Ohio and the U.S. overall is through employers as part of a benefits package. In 2024, almost 6 million Ohioans received coverage through ESI, accounting for about half of the total population. The prominence of ESI stems from federal policy decisions that made this form of coverage tax exempt,[47] amounting to nearly $300 billion in foregone tax revenue in 2022.[48]

Coverage availability

The tax-exempt status of ESI encourages employers to offer health coverage and employees to accept it rather than find insurance elsewhere. However, the elevation of ESI as a primary source of coverage has important drawbacks, including:

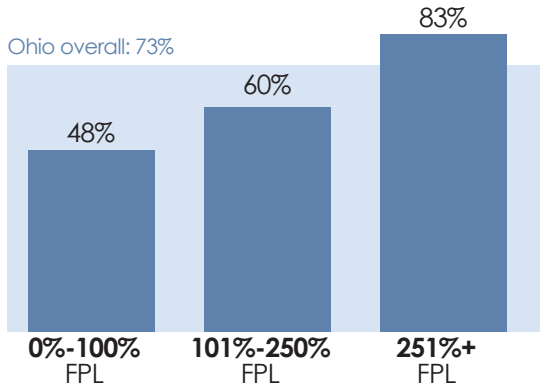
- Fragmentation in the insurance system
- Strain on small businesses
- Discouraging individuals from changing jobs or pursuing entrepreneurship[49]

Additionally, plans can still be expensive for employees, and many workers are not offered coverage.

Figure 8. **Employees offered employer-sponsored health insurance in Ohio**

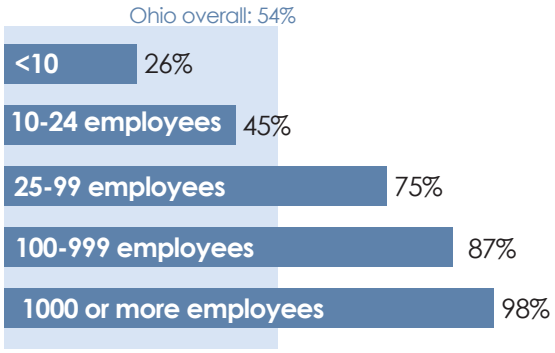
Although ESI is the most common form of coverage, it is not consistently available to all workers: Lower-income Ohioans and Ohioans working for small businesses are much less likely to have an offer of coverage through their employer.

Percent of working Ohioans, ages 19 and older, who were offered health insurance through their employer, by income, 2025



Source: HPIO analysis of Ohio Medicaid Assessment Survey

Ohio private-sector employers offering insurance, by number of employees, 2025



Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, Medical Expenditure Panel Survey Insurance Component

Employees who lose their coverage due to a change in their work situation (e.g., job loss or losing full-time status) are eligible for **Continuation of Health Coverage through COBRA**, which allows the covered individual or family to remain on the employer health plan for up to 1.5 years (3 years in limited situations). However, the employee becomes responsible for the full insurance cost.

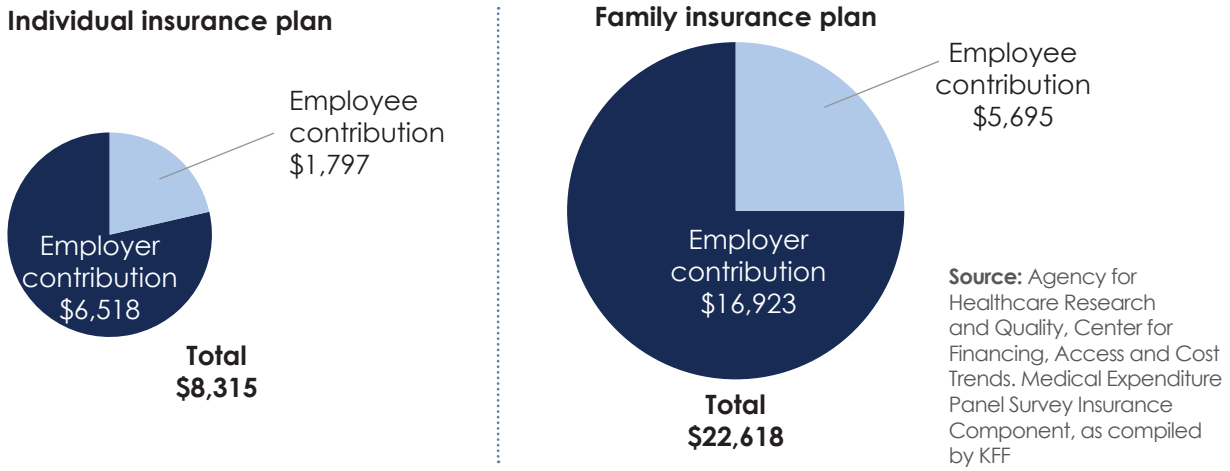
Costs

Costs have risen considerably for employer-sponsored plans over the last decade, including premiums and out-of-pocket expenses like deductibles. In Ohio, the average employer-sponsored premium in 2024 for a family plan was over $22,000, though a large percentage of the total is usually covered by the employer ($16,923 on average), as shown in figure 9. Even when coverage is offered, employees at small businesses and in lower-wage positions tend to have a smaller percentage of their total premium covered by their employer.[50]

Because health insurance is part of an employee's full compensation package, rising healthcare costs can contribute to wage stagnation.[51] Some studies have found that increased premiums are associated with decreased annual wages and may also contribute to rising income inequality.[52]

Despite rising costs and potential impacts on wages, ESI plans tend to be highly popular amongst enrollees. A 2026 survey found that nine in 10 workers are satisfied with their ESI coverage, and more than 95% see this coverage as critical to their household's financial security.[53]

Figure 9. **Average annual employer-sponsored premium for individual and family plans in Ohio, 2024**



Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey Insurance Component, as compiled by KFF

Regulation

Regulation of employer-sponsored plans is split between the state and federal governments. ERISA, which regulates non-compensation employment benefits like health insurance, pre-empts state insurance regulations for employers who administer their own health insurance plans (i.e., **self-insured** employers). Approximately three out of five Ohioans employed in the private sector were covered by a self-insured plan in 2024.[54] Employees at large companies are most likely to be covered by a self-insured plan. While self-insuring employers are directly responsible for the costs of medical claims, they often use **third-party administrators** to help manage the plans. There are also some **regulatory differences** between small group (up to 50 employees) and large group (51+ employees) plans, including the ACA employer mandate that applies only to large group plans.

As of 2026, ODI estimated that it had jurisdiction over only 11% of Ohio's health insurance market.[55] This includes small (50 or fewer employees) and large group (more than 50 employees) **fully insured** plans, in which an employer purchases coverage from an insurer who bears the financial risk.

Small businesses and health coverage

Employers with fewer employees face numerous barriers to offering affordable health insurance, including a small and unstable risk pool, high administrative costs and unpredictable annual expenditures.[56] This means that small businesses are less likely to be able to offer affordable coverage, impacting their ability to compete with larger employers for talented workers.[57] Some new models have emerged that can help small employers offer coverage, including:

- **Multiple Employer Welfare Arrangements (MEWAs)—** Allow two or more employers not under common ownership to pool contributions and offer health benefits to employees.[58] MEWAs are regulated by both state and federal law.[59] They may be exempt from certain ACA rules (e.g., the essential health benefit mandate) if treated as a large-group plan.[60]
- **Association health plans (AHPs)—** A type of MEWA where a group of employers or self-employed individuals must share a similar trade or industry. AHPs can be fully insured or self-insured.[61]
- **Individual Coverage Health Reimbursement Arrangements (ICHRAs)—**As an alternative to traditional group coverage, employers may help to directly reimburse employees for qualified medical expenses, including premiums for individual coverage that employees secure themselves.[62] Qualified Small Employer Health Reimbursement Arrangements are available for small businesses not offering any other coverage.[63] CMS now refers to ICHRAs as **Custom Health Option and Individual Care Expense (CHOICE)** Arrangements.

Local and state government employee benefits

Government employees often have access to comprehensive health insurance, with coverage functioning similarly to private employer-sponsored coverage. Although self-insured, state employee health insurance plans in Ohio are regulated by ODI.[64] The Ohio Department of Administrative Services manages these plans with third party administrators.[65]

ACA marketplace and direct-purchase coverage	
Ohioans covered	**~550,000** (2024)
Coverage eligibility	Anyone can select a plan through the ACA marketplace or directly from an insurer (subject to enrollment sign-up periods or experiencing qualifying events). People with low incomes may be eligible for subsidized marketplace coverage.
Costs for Ohioans	Varies significantly by individual plan and whether the consumer is eligible for subsidies. The average marketplace plan premium in 2026 after subsidies was $233 per month in Ohio. Many plans also have large deductibles and other required cost sharing.
Regulation	The ACA regulates marketplace and off-exchange plans, including the availability of marketplace subsidies and plan benefit requirements. States also have roles in regulating these plans.

After ESI, the main sources of private insurance in the U.S. are available through the ACA marketplace or (less commonly) off-exchange coverage directly from an insurer. These forms of coverage are sometimes referred to as nongroup plans. In 2010, the ACA mandated the creation of health insurance marketplaces (sometimes called exchanges) in each state, through which consumers can shop for and select a private health plan that meets certain federal requirements and receive subsidies if eligible.[66]

Coverage availability

ACA marketplace plans are broadly available to consumers; however, their main purpose is to address situations where people have limited affordable health insurance options. Subsidies to decrease the cost of coverage are restricted to specific populations (see Costs section below).

Before ACA marketplaces, people who were ineligible for public programs like Medicaid and without an offer of affordable insurance through their employer would have to purchase an individual plan directly from an insurer, which tended to be expensive[67], or go without insurance entirely. Common occupations of people purchasing individual ACA marketplace plans include:[68]

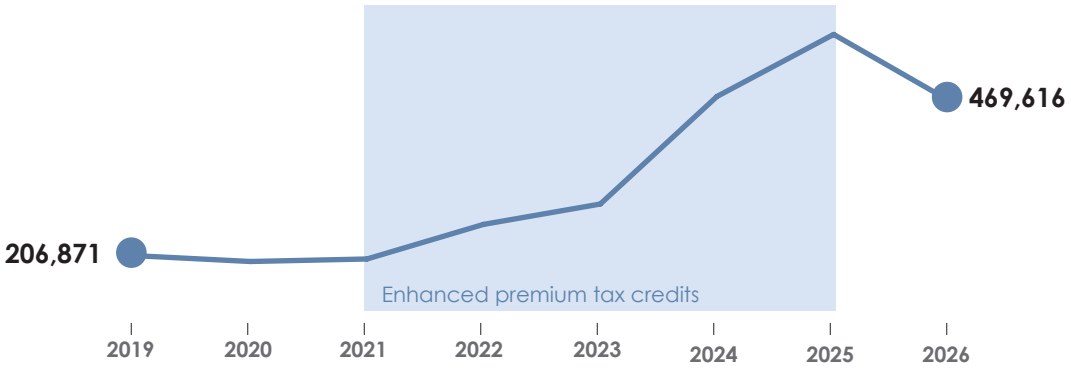
- Chiropractors and dentists
- Farmers, ranchers and other agricultural managers
- People who are self employed or working gig jobs (e.g., ridesharing)

Because of the creation of health insurance marketplaces in every state, direct-purchase plans have become less common, though they still exist. Insurers participating in the marketplace must offer identical mirrored plans that can be purchased directly (called **off-exchange plans**) and may also offer other off-exchange plans.[69]

Enrollment for ACA marketplace and direct-purchase off-exchange plans is generally open from November 1 to January 15 each year, though a consumer can also start coverage following a qualifying life event.[70]

Figure 10. **ACA marketplace coverage, Ohio, 2019-2026**

Number of individuals who selected a marketplace plan, Ohio, 2019-2026



Source: Centers for Medicare and Medicaid Services Marketplace Open Enrollment Period Public Use Files

In Ohio, marketplace enrollment was relatively low until 2021, when Congress passed enhanced subsidies that expanded income eligibility for subsidized coverage and decreased premiums for lower income families. Enhanced subsidies expired in 2025. For more information, see HPIO's policy brief on **updated Ohio enrollment in the federal ACA marketplace**.

Because of enhanced subsidies, marketplace enrollment in Ohio increased to nearly 600,000 in 2025 (figure 10). Following the expiration of these subsidies, over 100,000 consumers, many of whom lack alternative sources of affordable insurance, dropped coverage. More recent data collected in 2026 indicates that total coverage loss was even higher due to disenrollment as individuals fell behind on their premium payments.[71]

Costs

Marketplace plans are offered at four different "**metal levels**" of benefit and cost sharing coverage: bronze, silver, gold and platinum. These four coverage tiers vary based on the percentage of medical costs that the health plan will pay as opposed to what the consumer will pay out-of-pocket (called **actuarial value**). Platinum-level plans have the highest premiums but lowest levels of cost sharing, while bronze level plans have the lowest premiums but higher levels of cost sharing.

For people with lower incomes, costs can be lowered through two built-in subsidies:

Premium tax credits. Reduce the cost of ACA marketplace plans by setting a cap on an individual or family's monthly premium. To be eligible for the tax credit, ACA marketplace enrollees must:

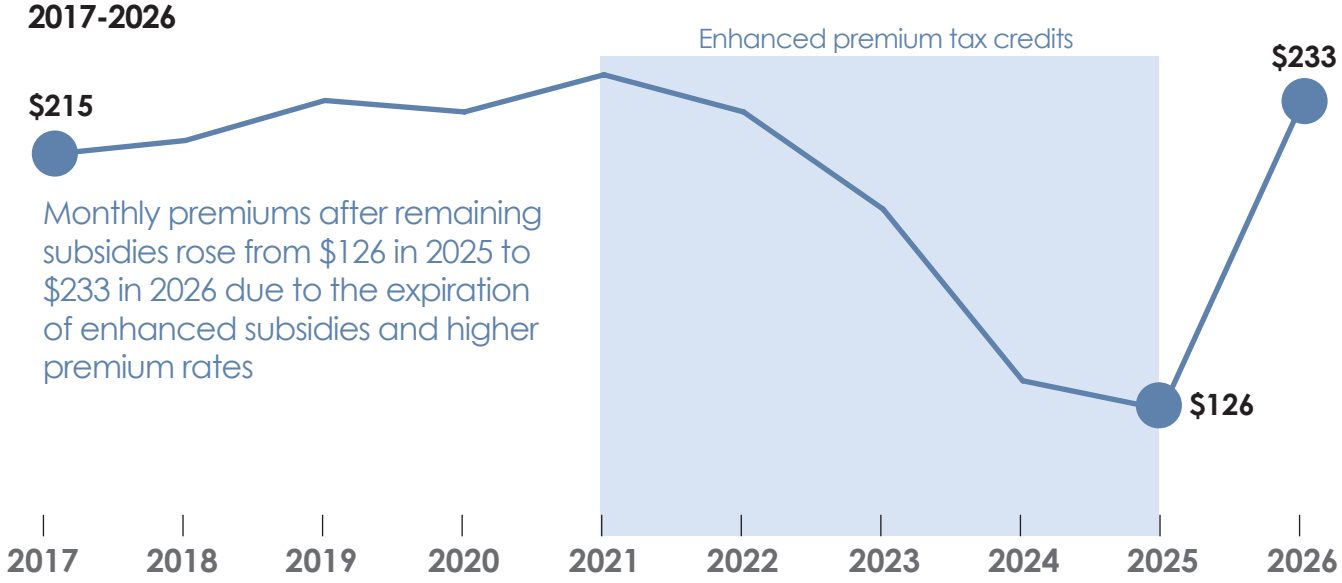
- Have a household income between 100% and 400% of the federal poverty level (FPL)
- Not be eligible for coverage through a public health insurance program like Medicaid or Medicare or have access to affordable coverage through an employer plan
- Not be claimed as a dependent by another person
- If married, file a joint tax return

Cost sharing reductions. Reduce out-of-pocket expenses for the lowest-income ACA marketplace plan enrollees. To receive a cost-sharing subsidy, individuals must:

- Be eligible for the premium tax credit
- Have a household income no greater than 250% FPL
- Enroll in a silver-level marketplace plan

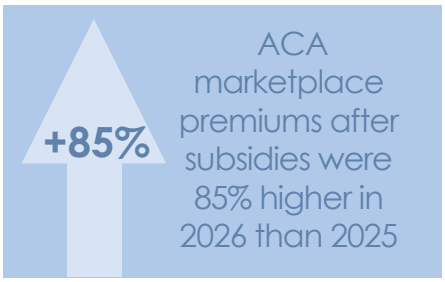
For more information on marketplace subsidies and income eligibility levels, visit **Healthcare.gov**.

Figure 11. **Average monthly premiums per person for ACA marketplace plans in Ohio, 2017-2026**



Source: Centers for Medicare and Medicaid Services, Marketplace Open Enrollment Period Public Use Files

The ACA also created **catastrophic plans** for young, healthy individuals who want a low-premium plan that still covers essential health benefits. Catastrophic plans have a very large deductible ($10,600 for an individual or $21,200 for a family in 2026).[72] The Trump administration has taken steps to expand access to these plans in recent years.[73] Bronze and catastrophic marketplace plans are considered high-deductible health plans and can be paired with tax-advantaged health savings accounts. However, consumers selecting catastrophic plans are **not eligible for marketplace subsidies**.



In 2026, the average Ohio premium for ACA marketplace plans was $233 after accounting for subsidies (figure 11). While the total amount of assistance differs depending on income level, 83% of Ohioans received a premium tax credit in 2026.[74] Enrollment data from 2026 also indicates that, compared to previous years, Ohioans were more likely to select bronze plans.[75]

Regulation

The ACA sets clear requirements for the individual coverage (i.e., non-group) market, including both on-exchange marketplace plans and off-exchange plans. These plans must cover essential health benefits and adhere to actuarial ratings requirements.[76] However, there is still variability across individual plans in terms of the benefits offered. Some may cover additional health benefits like vision and dental, and there can be restrictions on the number of services used for certain types of treatment.[77]

Some states manage their own exchanges, which provides them with additional flexibility over marketplace plan offerings.[78] For example, states can build in enhanced financial support for consumers, modify enrollment timelines or offer state-run health plans. Ohio, along with 27 other states, uses the **federal health insurance marketplace Healthcare.gov**, so it does not have this additional level of control.

The state regulates both on-exchange and off-exchange plans as well.[79] For example, ODI conducts reviews of insurance plans on the marketplace and monitors proposed premium increases each year.[80] Off-exchange plans are regulated similarly by the state, though some requirements only apply to marketplace plans.[81]

Non-ACA compliant plans

Certain forms of direct-purchase coverage serving specific populations or situations may not be subject to state or federal consumer protections and comprehensive coverage requirements. These include:

- **Farm Bureau plans**, available to members of the American Farm Bureau Federation, an agricultural lobbying organization with state-level affiliates like the **Ohio Farm Bureau**.[82]
- **Healthcare sharing ministries**, where members must agree to a common set of religious or ethical beliefs and help pay for medical expenses of other members through monthly contributions.[83] These ministries do not function as insurance, and there is no guarantee of payment for medical bills.
- **Hospital or other fixed indemnity plans** pay a limited predetermined amount for certain medical events or hospitalizations, regardless of the actual expenses incurred.[84] While filed and approved by the state, these plans do not provide comprehensive coverage and instead serve as a form of income replacement.[85]
- **Short-term, limited duration insurance (STLDI)**, which serves as temporary coverage for individuals transitioning between insurance plans, such as people changing jobs.[86] As of 2025, STLDI is available in 36 states, including Ohio.[87] Ohio allows short-term plans to last as long as one year.

An oft-cited benefit of these alternative coverage options is lower premiums. However, because these types of plans are not ACA compliant, consumers may be subject to higher deductibles and out-of-pocket costs or be denied coverage for for pre-existing conditions.[88] These plans can also destabilize the individual insurance market by disproportionately attracting healthier individuals who expect to minimize their healthcare usage. For more information, see the Commonwealth Fund's **Policy Explainer**.

Additional resources

- **Health Insurance Terminology Basics Blog** (State Health Access Data Assistance Center)
- **The Regulation of Private Insurance** (KFF)
- **What Consumers Need to Know About Health Coverage That Doesn't Comply with the Affordable Care Act** (Commonwealth Fund)
- **Medicaid Basics** (Health Policy Institute of Ohio)
- **Health Insurance Guide** (Ohio Department of Insurance)
- **The Affordable Care Act 101** (KFF)

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